1 STATE OF MINNESOTA DISTRICT COURT 13:14:10

2 COUNTY OF RAMSEY SECOND JUDICIAL DISTRICT

3

4
- -
5 THE STATE OF MINNESOTA,
BY HUBERT H. HUMPHREY, III,
6 ITS ATTORNEY GENERAL,

7 AND

8 BLUE CROSS AND BLUE SHIELD
OF MINNESOTA,
9
PLAINTIFFS,
10
VS. FILE NO. C1-94-8565
11
PHILIP MORRIS INCORPORATED, R.J.
12 REYNOLDS TOBACCO COMPANY, BROWN &
WILLIAMSON TOBACCO CORPORATION,
13 B.A.T. INDUSTRIES P.L.C., LORILLARD
TOBACCO COMPANY, THE AMERICAN
14 TOBACCO COMPANY, LIGGETT GROUP, INC.,
THE COUNCIL FOR TOBACCO RESEARCH-U.S.A.,
15 INC., AND THE TOBACCO INSTITUTE, INC.,

16 DEFENDANTS.
- -
17

18
VIDEOTAPE DEPOSITION OF
19 BARBARA J. BOWERS, M.D.

20 July 23, 1997
1:14 p.m.
21

22 REPORTED BY: JENNIFER S. SATI
REGISTERED PROFESSIONAL REPORTER
23 CERTIFIED REALTIME REPORTER
RAY J. LERSCHEN & ASSOCIATES
24 620 PLYMOUTH BUILDING
MINNEAPOLIS, MINNESOTA 55402
25

1 VIDEOTAPE DEPOSITION OF BARBARA J. BOWERS,

http://legacy.library.ucsf.edu/tid/vxp05a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/xqxd0001

2 M.D., taken at the Law Offices of Robins, Kaplan,

3 Miller & Ciresi, 2800 LaSalle Plaza, 800 LaSalle

4 Avenue, Minneapolis, Minnesota, on the 23rd day of

5 July, 1997, commencing at 1:14 p.m., before Jennifer

6 S. Sati, Notary Public.

7

8 * * * *

9

A P P E A R A N C E S

10

11 On Behalf of the Plaintiffs:

12 Robins, Kaplan, Miller & Ciresi
2800 LaSalle Plaza
13 800 LaSalle Avenue
Minneapolis, Minnesota 55402

14

BY: Howard R. Orenstein

15

16 On Behalf of Lorillard Tobacco Company:

17 Shook, Hardy & Bacon
One Kansas City Place
18 1200 Main Street
Kansas City, Missouri 64105-2118

19

BY: Donald J. Kemna

20

21 ALSO PRESENT:
GARY W. WILLIAMS, Senior Analyst
22 Shook, Hardy & Bacon

23 JOE FERRARO, Video Deposition Company

24 * * * *

25

1 I N D E X

2 EXAMINATION BY: PAGE

3 MR. KEMNA 5

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EXHIBIT INDEX

NUMBER	DESCRIPTION	MARKED
2500	Notice of Taking Deposition of Barbara Bowers	10
2501	Curriculum Vitae of Barbara Jean Bowers, M.D.	29
2502	Article entitled, "Multimodal therapy in the treatment of breast cancer"	34
2503	Plaintiffs' Expert Report, Barbara J. Bowers, M.D., June 2, 1997	37
2504	6-3-97 letter to Mr. Sipkins from Mr. Orenstein	39

THE VIDEOGRAPHER: This is the beginning of the videotape deposition. Today's date is July 23, 1997. And the time is now 1:14 p.m. My name is Joe Ferraro, a video technician associated with Ray J. Lerschen & Associates. Today's witness is Dr. Barbara Bowers. 13:14:24 13:14:28 13:14:38 13:14:40 13:14:42

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May we have introduction of the counsel, followed by the swearing in of the witness. 13:14:44 13:14:48

MR. KEMNA: I'm Don Kemna with Shook, Hardy & Bacon, Kansas City, representing Lorillard. This is Gary Williams, he's with my office in Kansas City. 13:14:52 13:15:02 13:15:04

MR. ORENSTEIN: He's not an attorney? 13:15:06

MR. KEMNA: He's not an attorney. 13:15:08

MR. ORENSTEIN: Okay. I'm Howard Orenstein with Robins, Kaplan, Miller & Ciresi for the State of Minnesota and Blue Cross/Blue Shield of Minnesota. 13:15:10 13:15:14 13:15:16 13:15:26

BARBARA J. BOWERS, M.D.
the Witness in the above-entitled
matter after having been duly sworn
testifies and says as follows:

EXAMINATION

BY MR. KEMNA:

Q. Doctor, would you give your full name and office address for the record, please. 13:15:32 13:15:34

A. Dr. Barbara J. Bowers, 800 East 28th Street, 405 Piper Building, Minneapolis, Minnesota 55407. 13:15:42 13:15:46

Q. Doctor, I take it that you've had your deposition taken before? 13:15:52 13:15:54

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9 A. Yes. 13:15:54

10 Q. Approximately how many times have you had your 13:15:58

11 deposition taken? 13:15:58

12 A. I think once. 13:16:02

13 Q. Okay. Do you recall the case that you were deposed 13:16:06

14 in? 13:16:06

15 A. The case that I was deposed in was a case for our 13:16:12

16 office when we were -- we had fired another 13:16:18

17 physician, and it was a case of dealing with whether 13:16:24

18 we had done the -- if we had fired him 13:16:32

19 appropriately. 13:16:32

20 Q. Okay. So it was a -- it was really a 13:16:38

21 business-oriented lawsuit? 13:16:40

22 A. Correct. 13:16:40

23 Q. Involving your medical practice and one physician 13:16:46

24 who had been employed with your practice? 13:16:48

25 A. Correct. 13:16:50

1 Q. It relates in no way to a malpractice action, for 13:16:52

2 instance?

3 A. No. And I was involved in another case -- now I 13:17:00

4 can't remember if I actually had a -- was deposed 13:17:02

5 for that where one of my patients -- I was summoned 13:17:06

6 to court to testify for one of my patients in a case 13:17:10

7 that she was -- which was a malpractice case against 13:17:16

8 another physician. 13:17:16

9 But I don't remember whether I actually 13:17:18

10 had a deposition in that case or if I was just 13:17:22

11 brought to court and asked questions. 13:17:22

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12 Q. Okay. So you actually testified at the trial of 13:17:28
13 that matter? 13:17:28
14 A. That's right. And then I had -- there was another 13:17:38
15 case where I was an expert witness many years ago 13:17:40
16 for a case, and I think I've outlined all of the 13:17:44
17 cases that I was involved in. 13:17:48
18 But that was a case, again, for a patient 13:17:58
19 that wasn't my patient but I was the expert witness 13:18:00
20 in another malpractice case. 13:18:02
21 Q. Okay. We'll talk a little bit about perhaps some 13:18:08
22 more detail regarding those cases in a moment. 13:18:10
23 Since you have been through a deposition 13:18:14
24 before, I take it you have an understanding for the 13:18:16
25 procedure? 13:18:16

1 A. Yes. 13:18:18
2 Q. I will be asking you a series of questions. If you 13:18:24
3 understand the questions, I'd say feel free to go 13:18:28
4 ahead and provide a response. 13:18:30
5 Sometimes in depositions of medical or 13:18:32
6 scientific people, there are technical terms that 13:18:36
7 while lawyers try to be adept at using your 13:18:40
8 terminology, we sometimes are inaccurate in the 13:18:44
9 usage. 13:18:44
10 And I'd say if the question does not make 13:18:48
11 sense to you, please let me know. I'll do my best 13:18:50
12 to repeat the question and then we can assume that 13:18:56
13 when you provide answers that you've understood the 13:18:58

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14 nature of the question. 13:19:02

15 Is that okay? 13:19:02

16 A. That's fine. 13:19:04

17 Q. Going back to your testimony in the two matters I 13:19:12

18 understand that you provided some testimony as an 13:19:14

19 expert witness. Let's talk about each one of those 13:19:20

20 in the -- whichever one you choose to describe 13:19:24

21 first, who requested your services as an expert 13:19:30

22 witness in the case? 13:19:30

23 MR. ORENSTEIN: Objection; 13:19:32

24 mischaracterizes the testimony. 13:19:32

25 BY MR. KEMNA:

1 Q. You can go ahead and answer. 13:19:38

2 A. Okay. The first case was a case that the attorneys 13:19:46

3 for the plaintiff requested that I look at the case 13:19:52

4 and provide testimony. 13:19:54

5 Q. Tell me, if you would, the nature of the allegations 13:20:00

6 made in the lawsuit as against the defendant. And 13:20:06

7 if you would, let me know if the defendant was a 13:20:08

8 doctor or a treating institution or both. 13:20:10

9 MR. ORENSTEIN: Objection; compound 13:20:14

10 question. Objection; lack of foundation. 13:20:16

11 BY MR. KEMNA: 13:20:18

12 Q. You can go ahead. 13:20:18

13 A. It goes back quite a ways. I'm not sure that I 13:20:24

14 remember specifically who the defendants were. 13:20:28

15 Q. That's okay. If you can remember something about 13:20:30

16 the nature of the lawsuit. 13:20:32

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17 A. All I remember about the lawsuit after these years 13:20:36
18 is that it was a lady with colon cancer that was 13:20:42
19 seen on multiple occasions with symptoms and it was 13:20:48
20 not diagnosed until shortly before her death from 13:20:52
21 the disease. 13:20:52
22 Q. Okay. Was it a lawsuit based on, then, the failure 13:21:00
23 to diagnose the condition by the treating physician? 13:21:04
24 MR. ORENSTEIN: Objection; lack of 13:21:06
25 foundation. 13:21:06

1 THE WITNESS: You know, I would have to go 13:21:08
2 back and look at the case. It's been that many 13:21:10
3 years. 13:21:10
4 BY MR. KEMNA:
5 Q. Okay. What did you do to prepare to offer testimony 13:21:16
6 in that case, if you recall? 13:21:20
7 A. You know, I looked at old records from the clinics, 13:21:24
8 from testimony from the patient that the patient had 13:21:30
9 documented in family path reports. 13:21:36
10 Q. Okay. By the time you were involved in the case, 13:21:44
11 was the patient that you've referred to deceased? 13:21:50
12 A. Yes. 13:21:50
13 Q. The other matter that you mentioned that you 13:21:56
14 participated in as an expert, would you tell me who 13:22:00
15 asked you to participate in the case? 13:22:02
16 A. I'm not sure how you define "expert" in that. I was 13:22:06
17 the oncologist taking care of the patient and I was 13:22:10
18 asked to testify about her condition when she came 13:22:18

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19 to see me and the care that I gave her during that 13:22:22
20 period of time. 13:22:24
21 She had a nodule on a chest x-ray that had 13:22:30
22 been not read properly. And the second chest x-ray, 13:22:34
23 showed the disease several months later. 13:22:38
24 Q. Okay. Who were the defendants in that lawsuit, if 13:22:42
25 you recall? 13:22:42

1 A. Again, I'm not sure if it was the treating doctor or 13:22:52
2 if there was something with the hospital. I don't 13:22:54
3 remember clearly who the defendants were. 13:22:56
4 Q. Okay. But you were treating physician in that 13:23:02
5 case? 13:23:02
6 A. I was the treating physician and not the expert 13:23:04
7 witness that came in to testify. 13:23:06
8 Q. Okay. Were you a defendant in that lawsuit? 13:23:12
9 A. No. 13:23:14
10 Q. Were treating physicians that you were associated 13:23:20
11 with in the treatment of the patient involved as 13:23:26
12 defendants in that lawsuit? 13:23:28
13 MR. ORENSTEIN: Objection; calls for a 13:23:28
14 legal conclusion, lack of foundation. 13:23:32
15 BY MR. KEMNA:
16 Q. You can answer, if you know. 13:23:36
17 A. Yeah, I can't remember. I'd have to go back and 13:23:38
18 actually look at who was in what position. I mean, 13:23:42
19 there were many people associated, and I just don't 13:23:46
20 remember. 13:23:46
21 MR. KEMNA: Let's have this marked as the 13:23:56

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22 first exhibit. 13:23:56

23 (Defendants' Exhibit 2500 marked for 13:24:06

24 identification by the reporter.)

25 BY MR. KEMNA:

1 Q. Doctor, I'm going to hand you what has been marked 13:24:18

2 as Defendants' Exhibit 2500 and ask you to look at 13:24:22

3 that. Have you seen that document, Doctor? 13:24:26

4 A. No. 13:24:28

5 Q. Doctor, Defendants' Exhibit 2500 is entitled, 13:24:42

6 "Notice of Taking Deposition of Barbara Bowers." 13:24:46

7 Underneath that, "Expert Deposition." 13:24:50

8 Would you look at page 2 of the document 13:24:54

9 where you see a series of subparagraphs with small 13:25:02

10 case "a" through "e" on page 2, and continuing with 13:25:06

11 small case "f" on page 3. 13:25:14

12 I believe that in advance of the 13:25:18

13 deposition we've been provided with what is listed 13:25:24

14 under subparagraph "a" a full and complete report, 13:25:28

15 prepared and signed by the expert. That's the 13:25:32

16 characterization on this document. 13:25:36

17 Did you draft an expert report in this 13:25:38

18 case? 13:25:38

19 A. Yes. 13:25:40

20 Q. Okay. And is it your understanding that it's that 13:25:44

21 expert report that you drafted that was submitted by 13:25:46

22 plaintiffs' counsel in this case? 13:25:50

23 A. Yes. 13:25:50

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24 Q. Under subparagraph "d", it reads, "A listing of all 13:26:10
25 matters in which the expert has testified, by 13:26:12

1 deposition, at legislative or administrative 13:26:14
2 hearings or at trial, and the dates thereof." 13:26:18
3 We've talked about deposition testimony, 13:26:20
4 trial testimony. Have you ever been involved in 13:26:24
5 providing testimony before any legislative body? 13:26:26
6 A. No. 13:26:28
7 Q. Same question with respect to administrative 13:26:32
8 hearings. Any testimony in front of an 13:26:34
9 administrative authority, any hearing? 13:26:38
10 A. No. 13:26:38
11 Q. Any other matter where you may have provided some 13:26:46
12 testimony or statement under oath? 13:26:48
13 A. Not that I can remember. 13:26:50
14 Q. Subparagraph "e" reads, "A listing of all principal 13:27:00
15 treatises, articles, or documents relied upon by the 13:27:02
16 expert in support of his or her opinion." The word 13:27:08
17 "expert" is not included there. 13:27:12
18 Did you list any treatises, articles or 13:27:18
19 documents that you're relying upon for your opinions 13:27:20
20 in this case? 13:27:20
21 A. No. 13:27:20
22 Q. Are you relying on any -- 13:27:24
23 MR. ORENSTEIN: Counsel, I think you've 13:27:26
24 been referring to the report as submitted. We did 13:27:28
25 send you a letter, or we sent Mr. Sipkins a letter, 13:27:30

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1 indicating that she'd reviewed the expert reports of 13:27:36
2 Dr. Samet and Hurt and may be relying on those 13:27:38
3 reports in her testimony. 13:27:40
4 So what are you talking about when you ask 13:27:44
5 her the question? 13:27:46
6 MR. KEMNA: Well, what I'm talking about 13:27:50
7 is exactly how this reads in the notice. We can get 13:27:52
8 down to the specifics, and, you know, I appreciate 13:27:54
9 your input and, yes, we were advised through the 13:27:58
10 letter regarding the expert reports of other 13:28:00
11 experts. 13:28:00
12 MR. ORENSTEIN: Okay. 13:28:02
13 BY MR. KEMNA:
14 Q. And in particular, I'm looking for what you have 13:28:08
15 relied upon for formulating your expert opinion in 13:28:10
16 the case. And so I guess I'll go ahead and ask the 13:28:18
17 question again. You can keep in mind what 13:28:20
18 Mr. Orenstein mentioned, but I'll just give you the 13:28:26
19 question again. 13:28:26
20 Are there any treatises, articles or 13:28:30
21 documents that you've relied upon for your expert 13:28:34
22 opinion that you have not provided a listing of in 13:28:42
23 connection with the expert report submitted in the 13:28:44
24 case? 13:28:44
25 A. I am making the assumption that my expert opinion is 13:28:52

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what I have written and signed. I relied on no 13:28:56
treatises, articles or documents to write that, nor 13:29:02
had I reviewed any of the other expert opinions 13:29:04
before writing my opinion. 13:29:10
Q. Okay. Is it fair to say that you are not relying 13:29:18
upon the expert reports or expert opinions of other 13:29:24
experts in this case for the opinions that you 13:29:26
expect to express as an expert at the trial of this 13:29:30
matter? 13:29:30
MR. ORENSTEIN: Objection; 13:29:32
mischaracterizes her testimony. 13:29:32
BY MR. KEMNA:
Q. You can answer. 13:29:38
A. I'm not sure what the -- I'm not sure what that 13:29:46
question means. 13:29:48
Q. Okay. Let's take it step by step then. 13:29:50
A. Let's try it in medical terminology: None of that 13:29:54
made sense. 13:29:54
Q. Okay. It's not intended to confuse or make vague 13:30:00
any matter that's going on with regard to my 13:30:04
questioning. It's just that sometimes it's a little 13:30:06
cumbersome when you formulate a question like that. 13:30:10
And I understand; I'll try to rephrase it so it's 13:30:12
more straightforward. 13:30:14
You've submitted an expert report in the 13:30:18

case, and you've indicated by answer to a prior 13:30:20
question that you had not reviewed any of the expert 13:30:24

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3 reports of other experts in this case in advance of 13:30:26
4 actually writing the report as it was submitted to 13:30:30
5 plaintiffs' counsel; is that correct? 13:30:32
6 A. That's correct. 13:30:32
7 Q. Now, since the time that you drafted the expert 13:30:38
8 report for yourself, have you reviewed expert 13:30:42
9 reports of any other expert that you know to be 13:30:44
10 involved in this case on behalf of the plaintiffs? 13:30:48
11 A. Yes. 13:30:52
12 Q. Okay. And what expert reports did you review? 13:30:56
13 A. I believe all of those have been submitted. You 13:31:00
14 have a list of the reports that I received, and I 13:31:04
15 have not reviewed anything other than the list. 13:31:06
16 Q. Okay. List for me now, if you would, the names of 13:31:10
17 the expert reports which you have reviewed in 13:31:14
18 advance of this deposition? 13:31:16
19 A. Dr. Sammon (sic.), Dr. Hurt. I would have to look 13:31:26
20 at my -- 13:31:26
21 Q. Okay. The first doctor you mentioned was? 13:31:30
22 A. Sammon. 13:31:30
23 Q. Sammon? Of the reports that you reviewed of the 13:31:40
24 other experts, which of those reports would you say 13:31:44
25 that you would be relying upon in some respect for 13:31:46

1 offering expert opinions at the trial of this 13:31:50
2 matter? 13:31:50
3 MR. ORENSTEIN: Objection; calls for 13:31:52
4 speculation. 13:31:54

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5 BY MR. KEMNA:
6 Q. You can answer. 13:31:56
7 A. I would have no idea what I would be doing at trial 13:32:00
8 and offering opinions. 13:32:04
9 Q. Have you discussed with plaintiffs' counsel what the 13:32:08
10 scope of your expert opinions would be as you expect 13:32:10
11 to offer them at the trial of this matter? 13:32:12
12 A. You'll have to state that more clearly. 13:32:18
13 Q. Okay. You've drafted an expert report? 13:32:20
14 A. That's correct. 13:32:22
15 Q. And we'll talk about that in a little bit more 13:32:26
16 detail later. Apart from you drafting an expert 13:32:30
17 report, have you discussed with the plaintiffs' 13:32:34
18 counsel what your testimony is expected to be for 13:32:38
19 purposes of the trial of this case? 13:32:40
20 A. We've discussed issues from my report on -- that I 13:32:50
21 have filed. 13:32:50
22 Q. Yes. 13:32:52
23 A. And -- 13:32:54
24 MR. ORENSTEIN: I'm going to -- to the 13:32:56
25 extent the question calls for her to disclose our 13:32:58

1 conversations and my work product, I'm going to 13:33:02
2 instruct her not to answer. 13:33:02
3 So maybe you want to limit the question in 13:33:06
4 a way that it doesn't get into those areas. 13:33:08
5 MR. KEMNA: Well, I think the question 13:33:08
6 gets to the fact of discussions taking place, not 13:33:12
7 the substance of the discussions, as the question 13:33:16

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8 was originally phrased. 13:33:16

9 MR. ORENSTEIN: And that's how you mean 13:33:20

10 it? 13:33:20

11 MR. KEMNA: Excuse me? 13:33:20

12 MR. ORENSTEIN: Is that how you mean it? 13:33:22

13 MR. KEMNA: I think you can generally 13:33:26

14 expect that the question is as I mean it to be. If 13:33:30

15 I want to broaden the scope of it, I'll ask a 13:33:32

16 follow-up question. 13:33:34

17 BY MR. KEMNA:

18 Q. But if you can, answer the question as it stands. 13:33:36

19 A. Well, certainly we have talked about the content of 13:33:42

20 my report and how I've come to these conclusions 13:33:50

21 through my clinical practice. 13:33:50

22 Q. Right, and we will do that. My questions are really 13:34:00

23 geared to finding out the extent to which you have 13:34:04

24 an expectation of what you will testify about at the 13:34:08

25 trial of this matter. 13:34:10

1 Do you have an expectation about what the 13:34:12

2 scope of your testimony will be at the trial of this 13:34:16

3 matter? 13:34:16

4 A. The scope of what I will testify to at trial will be 13:34:22

5 what is in my expert opinion. 13:34:26

6 Q. Okay. And your expert opinion is as reflected in 13:34:34

7 the report that you drafted; is that correct? 13:34:36

8 A. Correct. 13:34:36

9 Q. And that expert opinion was drafted before you had 13:34:40

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10 reviewed any of the expert reports of other experts 13:34:44
11 involved on behalf of the plaintiff in this case; is 13:34:48
12 that correct?
13 A. That's correct. 13:34:48
14 Q. So is it fair to say that you are, in fact, not 13:34:52
15 relying upon the expert reports submitted by any 13:34:56
16 other experts that are involved in this case on 13:35:00
17 behalf of the plaintiffs? 13:35:00
18 MR. ORENSTEIN: Objection; 13:35:02
19 mischaracterizes the document. 13:35:04
20 THE WITNESS: I cannot answer that. I 13:35:10
21 still do not understand the question. 13:35:12
22 BY MR. KEMNA:
23 Q. Is there substance of the other expert reports that 13:35:20
24 you reviewed regarding experts other than yourself 13:35:22
25 in this case that makes a difference regarding what 13:35:28

1 your opinions are expected to be at the trial of 13:35:34
2 this case? 13:35:34
3 MR. ORENSTEIN: Objection; ambiguous. 13:35:36
4 THE WITNESS: I'm sorry, I still don't 13:35:44
5 understand the question. As far as what my opinion 13:35:52
6 is, whether I have -- you know, the fact that I did 13:35:56
7 not review the other experts but indeed have 13:35:58
8 reviewed the other expert opinions since I wrote 13:36:06
9 this, my opinion, so I still do not understand the 13:36:12
10 question. 13:36:12
11 BY MR. KEMNA:
12 Q. Okay. I understand the chronology, I understand 13:36:16

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13 that your report was drafted before you had an 13:36:18
14 opportunity to look at the expert reports of other 13:36:22
15 experts in this case. 13:36:24
16 The question gets to whether your review 13:36:30
17 of the reports of other experts in this case will 13:36:32
18 have anything to do with the testimony that you 13:36:36
19 provide in the trial of this matter? 13:36:38
20 A. It will not change my testimony. 13:36:40
21 Q. Okay. That's a step in the direction that I'm 13:36:48
22 headed. It will not change your testimony. 13:36:54
23 Do you feel that the reports that were 13:36:58
24 filed by experts, other than yourself, that you 13:37:00
25 reviewed are essential foundations for the opinions 13:37:06

1 that you will express at the trial of this matter? 13:37:08
2 MR. ORENSTEIN: Objection; calls for a 13:37:10
3 legal conclusion. 13:37:12
4 THE WITNESS: I'm not qualified to give a 13:37:14
5 legal opinion. 13:37:16
6 BY MR. KEMNA:
7 Q. Well, Doctor, it's not really a legal opinion. What 13:37:20
8 it asks is what is the foundation for the testimony 13:37:24
9 you expect to provide at the trial of this matter? 13:37:28
10 If it in some material respect involves 13:37:32
11 the content of expert reports and the opinions of 13:37:34
12 experts other than yourself, and you would see that 13:37:38
13 as necessary to support your opinions in this case, 13:37:42
14 then the answer would be yes. 13:37:46

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15 If you would not see it as necessary to 13:37:48
16 support the opinions in your case and you're, in 13:37:50
17 fact, not relying upon those other experts to 13:37:54
18 support your testimony, then the answer is no. 13:37:58
19 MR. ORENSTEIN: Counsel, I mean, you're 13:38:02
20 now starting to tell her what her answers might 13:38:06
21 mean. And I -- why don't you try to formulate the 13:38:08
22 question. 13:38:08
23 She obviously is not following it the way 13:38:12
24 you've asked, and I'm having a difficult time 13:38:14
25 following it the way you've asked. 13:38:14

1 What are you trying to find out? 13:38:28
2 BY MR. KEMNA:
3 Q. Well, I'd say without regard to opposing counsel's 13:38:32
4 question regarding whether you have an understanding 13:38:34
5 of what I'm getting at, let me just rephrase the 13:38:38
6 question and we'll try to get it as directly as we 13:38:42
7 can. 13:38:42
8 Do you rely on the opinions of other 13:38:48
9 experts in this case as support for your own 13:38:54
10 opinions to be expressed in this case? 13:38:56
11 A. In my expert testimony, I was asked to talk about 13:39:18
12 the care of the lung cancer patient, the work-up, 13:39:24
13 the follow-up of those patients. None of the other 13:39:28
14 experts address these issues. 13:39:30
15 Q. Okay. So can you provide an answer to the question 13:39:40
16 that was asked? 13:39:42
17 MR. ORENSTEIN: Objection; 13:39:42

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18 mischaracterizes her testimony. 13:39:46

19 BY MR. KEMNA:

20 Q. Would you like the court reporter to read back the 13:39:58

21 original question so you can have another 13:40:00

22 opportunity? 13:40:02

23 A. I hear the question, I just do not see how it 13:40:06

24 correlates to what my expert opinion is. I'm having 13:40:18

25 trouble understanding how we are juxtaposing these 13:40:24

1 issues. 13:40:24

2 Q. Well, maybe we can talk about other aspects of your 13:40:32

3 opinions and maybe we can come back to the topic and 13:40:34

4 maybe it will make more -- 13:40:36

5 A. More sense. 13:40:38

6 Q. -- more sense to you at that point, and we'll just 13:40:40

7 move on. 13:40:42

8 Subparagraph "f" on page 3 of Defendants' 13:40:52

9 Exhibit 2500 reads, "All notes, handwritings, 13:40:58

10 calculations or other documents of any kind or 13:41:00

11 nature existing at the time of the service of the 13:41:04

12 expert's signed report prepared in whole or in part 13:41:08

13 for this matter by the expert or by others at 13:41:10

14 his/her request." 13:41:14

15 As that reads, do you have any materials 13:41:18

16 that you believe would be responsive to that 13:41:20

17 description of materials that should be produced at 13:41:24

18 the deposition today? 13:41:26

19 A. No, I have none. 13:41:28

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20 Q. Let me follow-up with a few questions just to make 13:41:34
21 sure we're both seeing it the same way. 13:41:40
22 Do you have correspondence that you've 13:41:40
23 received from the plaintiffs' counsel in this case? 13:41:44
24 A. I have none. 13:41:44
25 Q. Have you sent any correspondence from your office to 13:41:48

1 plaintiffs' counsel in this case? 13:41:50
2 A. My signed opinion. 13:41:54
3 Q. Okay. Anything else that you recall? 13:41:58
4 A. No, nothing else but this at the time that I signed 13:42:04
5 this. 13:42:04
6 Q. Okay. Do you have any notes that you have made in 13:42:10
7 the course of trying to prepare yourself to testify 13:42:12
8 in this matter or in connection with your 13:42:16
9 development of ideas for drafting your expert 13:42:20
10 opinion in this case? 13:42:22
11 A. No. 13:42:22
12 MR. ORENSTEIN: Objection; compound 13:42:24
13 question. 13:42:24
14 BY MR. KEMNA:
15 Q. Your answer is "no"? 13:42:26
16 A. My answer is "no." 13:42:28
17 Q. When did you first learn of this particular lawsuit 13:42:48
18 filed by the State of Minnesota against various 13:42:52
19 tobacco company interests? 13:42:54
20 A. I believe the first time I heard about this lawsuit 13:43:04
21 was on the news sometime in the spring. 13:43:06
22 Q. At sometime in the spring of 1997? 13:43:12

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23 A. Correct. 13:43:12

24 Q. Who first contacted you with regard to your 13:43:20

25 participation in this case? 13:43:20

1 A. Mr. Orenstein. 13:43:22

2 Q. Do you recall when that occurred? 13:43:26

3 A. No, I don't. 13:43:28

4 Q. Can you approximate for me, since the spring of 1997 13:43:36

5 was when you first learned of this case, can you 13:43:42

6 estimate the month of 1997 that you may have first 13:43:46

7 been contacted by Mr. Orenstein? 13:43:48

8 A. No, I can't. 13:43:50

9 Q. What was the nature of the contact? Was it a phone 13:44:02

10 call? 13:44:02

11 A. Correct. 13:44:02

12 Q. Okay. How long would you estimate that that phone 13:44:06

13 call lasted? 13:44:10

14 A. A few minutes. 13:44:14

15 Q. Okay. To the best of your recollection, what was 13:44:18

16 your understanding of what you were expected to do 13:44:22

17 in participating in this case after that first phone 13:44:24

18 call? 13:44:24

19 A. Our first phone call stated that we would get 13:44:32

20 together if I had an interest in possibly doing this 13:44:38

21 to talk about what type of commitment and what type 13:44:42

22 of report I would need to do for this case. 13:44:46

23 Q. Okay. Were you personally acquainted with 13:44:50

24 Mr. Orenstein or anyone at this law firm prior to 13:44:54

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25 that first contact? 13:44:56

1 A. I believe Kathy Flynn. 13:45:00
2 THE WITNESS: Is she a partner? 13:45:02
3 MR. ORENSTEIN: I can't testify. 13:45:04
4 THE WITNESS: I'm sorry. A friend of mine 13:45:06
5 by the name of Kathy Flynn is a mother of a friend 13:45:12
6 of my son who is associated somehow with the firm, 13:45:16
7 whether a partner or an associate or how legal firms 13:45:20
8 work, I'm not entirely sure. 13:45:22
9 BY MR. KEMNA:
10 Q. Okay. Do you know how Mr. Orenstein first found 13:45:28
11 that you may be interested in participating in this 13:45:32
12 case? How did he first come by contacting you? 13:45:34
13 A. He called me on the phone. 13:45:36
14 Q. Okay. Do you know why he contacted you versus many 13:45:40
15 other physicians in the area? 13:45:42
16 A. No. 13:45:42
17 Q. As a result of that initial contact, you indicated 13:45:48
18 there was some suggestion that you would get 13:45:52
19 together at some point to discuss the case. 13:45:56
20 Did that, in fact, occur? 13:45:56
21 A. Yes. 13:45:58
22 Q. Okay. Do you recall when that happened? 13:46:00
23 A. No. 13:46:00
24 Q. When the meeting occurred, did you come to the 13:46:08
25 offices of Mr. Orenstein for that discussion? 13:46:12

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A. No. 13:46:12
Q. Did he contact you at your office? 13:46:16
A. He came to my office. 13:46:16
Q. Okay. How long would you say that meeting lasted? 13:46:20
A. Probably 30 minutes. 13:46:22
Q. Okay. Do you recall what was discussed during that meeting? 13:46:28 13:46:30
MR. ORENSTEIN: Counsel, are you asking her to testify about the substance of our discussions? If so, I'm instructing her not to answer. 13:46:32 13:46:36 13:46:38 13:46:40
BY MR. KEMNA:
Q. Did that meeting occur in advance of you drafting your expert report? 13:46:52 13:46:52
A. Yes. 13:46:56
Q. Did you discuss during that meeting the content of your expert report? 13:47:00 13:47:02
A. No. 13:47:02
Q. What was your understanding, after coming out of that meeting with Mr. Orenstein, the nature of your participation in this case? 13:47:10 13:47:14 13:47:16
A. That they would be needing an oncologist to discuss what happened to the lung cancer patient once they were diagnosed. 13:47:28 13:47:34 13:47:34
Q. Okay. Anything else that you can recall that you 13:47:42

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1 might be expected to testify about coming out of 13:47:44
2 that meeting? 13:47:46
3 A. No. 13:47:46
4 Q. Any further meetings with plaintiffs' counsel, 13:47:52
5 Mr. Orenstein, or anyone else? 13:47:54
6 A. The only person I have met with has been 13:47:58
7 Mr. Orenstein, and we have had, I think, one or two 13:48:08
8 other meetings since then. 13:48:12
9 Q. Okay. You don't recall whether it's one or two? 13:48:16
10 A. No, I think it's two, but I'm not sure. 13:48:20
11 Q. Okay. Approximately how long did each one of those 13:48:24
12 meetings last? 13:48:24
13 A. One of the meetings lasted about two hours. If 13:48:40
14 there was another meeting, it was very short, a 13:48:44
15 matter of maybe 30 or 40 minutes. 13:48:48
16 Q. Okay. Did those meetings occur before or after you 13:48:56
17 began drafting your expert report? 13:48:58
18 A. The last one was after I drafted my expert report. 13:49:06
19 The other one, if I'm not getting it confused with 13:49:12
20 our first meeting, that's -- there were two of them, 13:49:16
21 they were very short, and that would have been 13:49:20
22 before I drafted anything, also. 13:49:22
23 Q. Okay. When did you actually draft your expert 13:49:26
24 report, the initial work on the report? 13:49:30
25 A. The last days of April, beginning of May. 13:49:40

1 Q. Did you go through a series of drafts on this report 13:49:42
2 before you submitted a final report? 13:49:44
3 A. I made an outline of the things I wanted to include 13:49:52

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4 in the report and dictated a report. Basically the 13:50:02
5 report remained unchanged, except for some 13:50:06
6 grammatical changes, changing of paragraphs. 13:50:12
7 Q. As a result of your meeting with Mr. Orenstein after 13:50:16
8 you had drafted your expert report, did you make any 13:50:18
9 changes in your report? 13:50:20
10 A. The -- after I -- 13:50:22
11 MR. ORENSTEIN: Objection; 13:50:24
12 mischaracterizes her testimony. 13:50:26
13 BY MR. KEMNA:
14 Q. You can go ahead and answer. 13:50:28
15 A. After I drafted the report and signed it, I did not 13:50:36
16 change the report, and we met after that. 13:50:38
17 Q. Did you seek input from anyone in constructing your 13:50:54
18 expert report or including the contents of your 13:50:58
19 expert report? 13:50:58
20 A. I guess I would have to say such as? I'm not sure 13:51:10
21 what you're referring to. I did not type the report 13:51:12
22 myself, so, obviously, there are other people 13:51:18
23 involved in preparing the report. 13:51:20
24 Q. Okay. Other than secretarial assistance or any 13:51:24
25 other kind of technical assistance to actually get 13:51:28

1 it into writing, did you seek the input or receive 13:51:30
2 input from any other individual toward drafting the 13:51:36
3 contents of your expert report? 13:51:36
4 A. I talked to no other physicians or health care 13:51:40
5 professionals, as far as for opinions. The opinions 13:51:44

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6 are mine. 13:51:44

7 Q. So you consulted with no one and you received input 13:51:50

8 from no one toward the content of the expert report 13:51:54

9 that you submitted in this case; is that correct? 13:52:02

10 A. That's correct. 13:52:06

11 MR. KEMNA: Let's have this marked as the 13:52:24

12 next exhibit. 13:52:24

13 (Defendants' Exhibit 2501 marked for 13:52:44

14 identification by the reporter.)

15 BY MR. KEMNA:

16 Q. Doctor, I'm going to hand you what's been marked as 13:52:50

17 Defendants' Exhibit 2501. Doctor, is that 13:53:00

18 exhibit -- 13:53:02

19 MR. ORENSTEIN: Counsel, I'm entitled to 13:53:04

20 get a copy of this. 13:53:06

21 MR. KEMNA: I'm sorry. 13:53:08

22 MR. ORENSTEIN: The practice in the past 13:53:08

23 has not been to take exhibits away from the 13:53:12

24 witnesses that have been previously marked. Are you 13:53:14

25 intending she's not able to refer back to that if 13:53:16

1 she needs to? 13:53:18

2 MR. KEMNA: She can if she needs to. My 13:53:20

3 practice is ordinarily to take an exhibit that isn't 13:53:26

4 expected to be the subject of any further 13:53:28

5 questioning, in the interest of keeping them 13:53:30

6 separated from any other papers that we might be 13:53:32

7 confused with during the deposition. 13:53:34

8 MR. ORENSTEIN: That's fine. 13:53:34

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9 BY MR. KEMNA:

10 Q. Doctor, Exhibit 2501 is a copy of your curriculum 13:53:46

11 vitae, correct? 13:53:46

12 MR. ORENSTEIN: Objection; 13:53:46

13 mischaracterizes the document. 13:53:48

14 BY MR. KEMNA:

15 Q. Is that a current version of your curriculum vitae? 13:53:54

16 MR. ORENSTEIN: Counsel, we've attached a 13:53:58

17 page at the end, which obviously is not a part of 13:54:00

18 her curriculum vitae, but was intended to comply 13:54:04

19 with the court order in this case. 13:54:06

20 So why don't we just put that on the 13:54:08

21 record instead of me having to make a series of 13:54:10

22 objections to all of your questions. 13:54:10

23 MR. KEMNA: That's fine, with that 13:54:12

24 clarification. 13:54:16

25 BY MR. KEMNA:

1 Q. The first two pages of Exhibit 2501 would be a 13:54:20

2 current version of your curriculum vitae; is that 13:54:24

3 correct?

4 A. That appears to be correct. 13:54:24

5 Q. Okay. I see that you attended the University of 13:54:30

6 Minnesota Medical School first in Duluth from '72 to 13:54:36

7 '74, and then in Minneapolis from '74 to '76. 13:54:40

8 Does the University of Minnesota have two 13:54:42

9 medical schools? 13:54:44

10 A. They have -- the University of Minnesota at Duluth 13:54:50

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11 at that time had two years of your training there 13:54:54
12 and two years at the main campus in Minneapolis. 13:54:58
13 It was part of a program to have students 13:55:04
14 be familiar with the rural areas. So it was part of 13:55:08
15 the same program. But some of us were in Duluth for 13:55:12
16 two years and everybody came down to Minneapolis for 13:55:16
17 the last two years. 13:55:16
18 Q. There are some students, then, that start in 13:55:18
19 Minneapolis and go all the way through here? 13:55:22
20 A. Correct. 13:55:22
21 Q. Okay. I see you're certified by the American Board 13:55:32
22 of Internal Medicine as of 1983; is that correct? 13:55:34
23 A. That's correct. 13:55:34
24 Q. Okay. Your practice emphasizes the field of 13:55:44
25 oncology; is that accurate? 13:55:46

1 A. That's accurate. 13:55:46
2 Q. Okay. Do you have certification in the subspecialty 13:55:52
3 of oncology? 13:55:52
4 A. I'm not boarded in medical oncology, no. 13:55:56
5 Q. Okay. Is there any reason why you haven't been 13:56:00
6 boarded in oncology? 13:56:02
7 A. It's not necessary to practice medical oncology as 13:56:06
8 long as you've done a fellowship in medical 13:56:10
9 oncology. And at the time that I finished medical 13:56:14
10 oncology, about 50 percent or so of the people did 13:56:18
11 their boards and others did not. It was not a 13:56:24
12 pressing issue. 13:56:24
13 Q. Have you ever sought certification in the field of 13:56:30

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14 oncology? 13:56:30

15 A. In 1985, I sat for my boards in medical oncology but 13:56:38

16 could not complete the exam because I was having 13:56:42

17 problems with a pregnancy. I had to leave the exam 13:56:46

18 early. 13:56:46

19 Q. Okay. So did you just withdraw your name from 13:56:50

20 consideration because of the circumstances? 13:56:52

21 A. With the boards for medical oncology, they're just 13:56:56

22 tests, and I just left the test early. 13:57:00

23 Q. Okay. So the result was, unfortunately, you failed 13:57:04

24 the exam but it was due to health circumstances? 13:57:08

25 A. Right. 13:57:10

1 MR. ORENSTEIN: Objection; 13:57:10

2 mischaracterizes the testimony. 13:57:14

3 BY MR. KEMNA:

4 Q. Doctor, you mentioned in the process of putting 13:57:36

5 together your expert report that you drafted an 13:57:42

6 outline? 13:57:42

7 A. Correct. 13:57:44

8 Q. Do you still have that outline? 13:57:44

9 A. No, I do not. 13:57:46

10 Q. Okay. You disposed of that? 13:57:48

11 A. Yes, I did. 13:57:50

12 Q. Okay. On the second page of your curriculum vitae, 13:57:58

13 there's an indication that you are editor and 13:58:00

14 contributor, or at least were editor and contributor 13:58:06

15 of "Post Graduate Medicine," 1983. 13:58:10

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16 Can you give me a little context for 13:58:14
17 that? What is "Post Graduate Medicine"? It looks 13:58:16
18 like that is some type of a publication? 13:58:18
19 A. It was a publication that one of my friends was an 13:58:22
20 editor for, and I would intermittently review 13:58:26
21 articles for him for content to see if they should 13:58:32
22 be published. 13:58:32
23 Q. Did you ever actually contribute articles for 13:58:36
24 publication in "Post Graduate Medicine"? 13:58:40
25 A. I don't remember ever contributing an article to 13:58:46

1 that. But that was 14 years ago, and it would not 13:58:56
2 have been a very significant article, if I did. So 13:59:00
3 it would not be something that I would remember. 13:59:00
4 MR. KEMNA: Would you mark this as an 13:59:10
5 exhibit, please. 13:59:12
6 (Defendants' Exhibit 2502 marked for 13:59:34
7 identification by the reporter.)
8 BY MR. KEMNA:
9 Q. Doctor, I hand you what has been marked as 13:59:46
10 Defendants' Exhibit 2502. That exhibit is an 14:00:08
11 article from the "American Journal of Clinical 14:00:16
12 Oncology," entitled, "Multimodal therapy in the 14:00:16
13 treatment of breast cancer." 14:00:18
14 Doctor, do you recognize that as one of 14:00:18
15 your publications? 14:00:18
16 A. Yes, I do. 14:00:20
17 Q. And that was published back in 1983; is that right? 14:00:28
18 A. That's correct. 14:00:28

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19 Q. Have you published any other articles? 14:00:32

20 A. None that I can remember. 14:00:34

21 Q. All right. Have you had any particular area of 14:00:40

22 research interests during the course of your career 14:00:44

23 that could have resulted in the publication of 14:00:50

24 articles in the medical or scientific literature? 14:00:54

25 MR. ORENSTEIN: Objection; ambiguous. 14:00:56

1 THE WITNESS: Not any research that I have 14:01:06

2 personally done. We all do clinical research and 14:01:08

3 have patients that are entered on clinical trials, 14:01:12

4 but we do not assess the data in those trials, nor 14:01:18

5 do we write any information on the responsiveness of 14:01:26

6 patients. 14:01:26

7 BY MR. KEMNA:

8 Q. Okay. So you, as a function of treating your 14:01:34

9 patients, and I assume working with interested 14:01:38

10 parties such as pharmaceutical companies, are 14:01:40

11 involved with some drug trial investigation? 14:01:44

12 MR. ORENSTEIN: Objection. 14:01:46

13 THE WITNESS: The trials that we are 14:01:48

14 involved with are the community oncology program. 14:01:54

15 There are several around the country that are funded 14:01:58

16 through the National Cancer Institute. 14:01:58

17 BY MR. KEMNA:

18 Q. Another item you have listed on your C.V. on page 2 14:02:24

19 is "Co-investigator, Community Oncology Cooperative 14:02:30

20 Program, Minneapolis." 14:02:36

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21 What was your role as co-investigator 14:02:38
22 within that program? 14:02:40
23 A. All the oncologists are co-investigators so that 14:02:42
24 they can enter -- their patients can take advantage 14:02:46
25 of the investigational programs. 14:02:50

1 Q. Okay. And the investigational programs relate to 14:02:56
2 what subject matter? 14:02:58
3 A. Some of them are preventive oncology. Some of them 14:03:02
4 are drug studies, working with oncologic -- certain 14:03:12
5 drugs for certain diseases. 14:03:14
6 Q. Okay. So that you contribute information to this 14:03:20
7 community oncology cooperative program based upon 14:03:24
8 your experience in treating patients in your office; 14:03:28
9 is that accurate? 14:03:28
10 A. Yes. The patients are screened by nurse clinicians 14:03:36
11 through the clinical oncology cooperative. There 14:03:40
12 are physicians that look at the data. The patients 14:03:46
13 are either candidates, not candidates, they decide 14:03:48
14 whether they want to participate in the study. 14:03:52
15 And then the nurses collect the data off 14:03:54
16 their chart for information into the study. We 14:04:00
17 don't specifically go through their charts and 14:04:02
18 contribute data, but we have the patients and we 14:04:06
19 take care of the patients, whether they're on study 14:04:08
20 or not. 14:04:08
21 Q. Okay. Has that ever put you in a position of 14:04:14
22 considering a compilation of the data within this 14:04:20
23 program to publish findings regarding certain 14:04:24

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24 chemotherapeutic regimens or other aspects of this 14:04:30
25 program? 14:04:32

1 A. Never. 14:04:32
2 Q. The data that you contribute to the program, does it 14:04:40
3 ever get compiled into some published form -- 14:04:44
4 MR. ORENSTEIN: Objection. 14:04:44
5 BY MR. KEMNA:
6 Q. -- for whatever purposes that this program is 14:04:48
7 established for? 14:04:48
8 MR. ORENSTEIN: Objection; lack of 14:04:50
9 foundation. 14:04:50
10 THE WITNESS: You would have to ask the 14:04:52
11 research nurses. 14:04:54
12 BY MR. KEMNA:
13 Q. Okay. 14:04:56
14 A. May I take just a one-minute break? 14:05:14
15 MR. KEMNA: Sure. 14:05:16
16 THE VIDEOGRAPHER: We're off the video 14:05:16
17 record. The time is 2:05 p.m. 14:05:22
18 (Defendants' Exhibit 2503 marked for 14:12:48
19 identification by the reporter.)
20 (Off the record.) 14:12:50
21 THE VIDEOGRAPHER: We're back on the video 14:15:38
22 record. The time is 2:15 p.m. 14:15:40
23 BY MR. KEMNA:
24 Q. Doctor, I'm going to show you another exhibit. It's 14:15:58
25 marked as Deposition Exhibit 2503. Doctor, that's a 14:16:38

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1 copy of your expert report that you have submitted 14:16:42
2 in this case; is that correct? 14:16:42
3 MR. ORENSTEIN: Counsel, objection. 14:16:44
4 Again, maybe I can avoid a series of objections 14:16:48
5 here. This is the main text of her report. It does 14:16:52
6 not include the attachments. Is that what you 14:16:54
7 mean? It's not a copy of everything she provided. 14:17:02
8 MR. KEMNA: Let's go off the record for a 14:17:08
9 moment. 14:17:08
10 THE VIDEOGRAPHER: We're off the video 14:17:10
11 record. The time is 2:17 p.m. 14:17:12
12 (Off the record.) 14:17:14
13 THE VIDEOGRAPHER: We're back on the video 14:19:06
14 record. The time is 2:19 p.m. 14:19:08
15 BY MR. KEMNA:
16 Q. Doctor, Mr. Orenstein has indicated there may be a 14:19:18
17 necessity to clarify exactly what we're referring to 14:19:22
18 as Defendants' Exhibit 2503. 14:19:30
19 Let's start by the question: When you 14:19:40
20 submitted your report to plaintiffs' counsel, what 14:19:42
21 all did you submit that would constitute the 14:19:46
22 report? 14:19:46
23 A. My opinion was submitted as Exhibit 2503. There 14:20:00
24 were other documents such as the curriculum vitae, a 14:20:08
25 list of articles that -- in cases that I may have 14:20:16

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1 either testified or deposed. Those are the items 14:20:20
2 that I submitted. 14:20:42
3 MR. KEMNA: Let's have this marked as the 14:20:46
4 next exhibit. 14:20:46
5 (Defendants' Exhibit 2504 marked for 14:20:58
6 identification by the reporter.)
7 BY MR. KEMNA:
8 Q. First of all, Doctor, as to any other type of 14:21:16
9 documentation submitted along with Exhibit 2503, you 14:21:24
10 just referred to your curriculum vitae and a list of 14:21:32
11 publications and cases? 14:21:34
12 A. I was asked what articles I may have written, and we 14:21:44
13 talked about one of those. And at the last page of 14:21:56
14 that exhibit -- 14:21:56
15 Q. That's Exhibit 2501 that you're referring to? 14:21:56
16 A. I'm not sure. This page is part of what I submitted 14:22:06
17 (indicating).
18 Q. Okay. So other matters that you may have testified 14:22:16
19 in, which is the last page of Defendants' Exhibit 14:22:18
20 2501, is reflective of the listing of matters that 14:22:26
21 you submitted to plaintiffs' counsel? 14:22:28
22 A. Correct. And then there was a subsequent 14:22:34
23 notification of the case where we -- the business 14:22:40
24 issue with firing the physician, and I believe that 14:22:46
25 was -- that information was submitted, but we've 14:22:48

1 already discussed that. 14:22:48

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2 Q. Yeah. So there was really a total, at least to your 14:22:52
3 recollection, of three matters that you provided 14:22:54
4 testimony in? 14:22:54
5 A. Uh-hm. 14:22:56
6 Q. Okay. So that's fine. Now as to your publication 14:23:04
7 that we've already talked about, that's the entirety 14:23:08
8 of your publication record? 14:23:10
9 A. According to my recollection, yes. 14:23:12
10 Q. Okay. Now, let's take a look at Exhibit 2503, which 14:23:30
11 is entitled, "Plaintiffs' Expert Report, Barbara J. 14:23:32
12 Bowers"; is that correct? 14:23:34
13 A. That's correct. 14:23:36
14 Q. The second page of that exhibit contains your 14:23:48
15 signature with a date of May 30, 1997; is that 14:23:54
16 correct?
17 A. That's correct. 14:23:54
18 Q. Is there anything else that you have considered 14:24:02
19 between May 30 and the deposition today regarding 14:24:06
20 the nature of your expert opinions that would 14:24:10
21 require some amendment to the expert report? 14:24:14
22 A. I'm not sure. You'll have to clarify that 14:24:22
23 question. I'm not sure what you mean by that. 14:24:24
24 Q. Is the report, as it was in existence on May 30, 14:24:30
25 1997, the entirety of your opinions as you intend to 14:24:38

1 express them in a report for the purposes of this 14:24:42
2 case? 14:24:42
3 A. This report is the entirety of my expert opinion on 14:24:50
4 the evaluation workup and treatment of the lung 14:24:56

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5 cancer patient. 14:24:56
6 Q. And that's the scope of the opinions you anticipate 14:25:00
7 giving in this case; is that correct? 14:25:04
8 A. That's correct. 14:25:06
9 Q. If you would turn to the third page of Exhibit 2503, 14:25:22
10 the second full paragraph on that page, let me just 14:25:24
11 read that first sentence, "I will be testifying 14:25:28
12 regarding lung cancer as an example of a disease 14:25:30
13 caused by cigarette smoking." 14:25:38
14 Do you expect to express an opinion 14:25:40
15 regarding the causation of lung cancer? 14:25:44
16 A. In terms of the use of the word "causation" being a 14:26:00
17 significant contributing factor in our patients, 14:26:04
18 yes. 14:26:04
19 Q. Okay. So you would expect, as part of your 14:26:08
20 testimony, to express an expert opinion regarding 14:26:10
21 the etiology of lung cancer? 14:26:14
22 MR. ORENSTEIN: Objection; 14:26:16
23 mischaracterizes her testimony. 14:26:16
24 THE WITNESS: I would be testifying that 14:26:24
25 cigarette smoking is a significant contributing 14:26:30

1 factor in our patients, as is held in the medical 14:26:36
2 community, as a significant factor for that group of 14:26:44
3 patients. 14:26:46
4 BY MR. KEMNA:
5 Q. Okay. Do you consider yourself to be an expert in 14:26:52
6 determining the etiology of lung cancer? 14:26:56

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7 MR. ORENSTEIN: Objection; ambiguous. 14:27:00
8 THE WITNESS: You'll have to rephrase 14:27:12
9 that. 14:27:12
10 BY MR. KEMNA:
11 Q. Is there terminology in that question, as it was 14:27:26
12 asked, that you don't understand? 14:27:26
13 A. As a medical oncologist in looking at a group of 14:27:38
14 patients and contributing factors, we understand 14:27:48
15 cigarette smoking to be a contributing factor for 14:27:52
16 our lung cancer patients. 14:27:54
17 Q. Okay. Having recognized this point in the course of 14:28:08
18 your practice, have you taken it upon yourself to 14:28:14
19 investigate the basis for drawing some type of 14:28:20
20 conclusion about the idea that cigarette smoking is 14:28:24
21 a contributing factor to lung cancer? 14:28:26
22 A. What do you mean by "idea"? 14:28:30
23 Q. Let me rephrase the question. 14:28:34
24 A. Yes, please. 14:28:36
25 Q. Have you made it a point to study any of the 14:28:46

1 underlying evidence regarding the point that you 14:28:54
2 just expressed that smoking is a contributing factor 14:28:58
3 to lung cancer? 14:29:00
4 A. I have reviewed epidemiologic evidence that shows 14:29:08
5 that point, such as that expressed by Dr. Sammon. 14:29:16
6 Q. Other than the report of Dr. -- you're referring to 14:29:30
7 Dr. Samet, not Dr. Sammon; is that correct? 14:29:34
8 A. I'm sorry, Samet. My tongue gets stuck. 14:29:38
9 MR. ORENSTEIN: She was thinking of her 14:29:42

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10 lunch. 14:29:42

11 THE WITNESS: Yes, that I didn't have. 14:29:46

12 BY MR. KEMNA:

13 Q. Did you refer to any other material other than -- 14:29:52

14 well, let me rephrase that. 14:29:54

15 In coming to some conclusion, as it 14:29:58

16 appears that you have, that smoking is a 14:30:00

17 contributing factor to lung cancer, have you ever 14:30:04

18 reviewed any of the evidence underlying that 14:30:06

19 conclusion in any other form than Dr. Samet's expert 14:30:14

20 report? 14:30:14

21 A. Things such as the Surgeon General's statement and 14:30:24

22 various medical conferences over the years talking 14:30:34

23 about the epidemiology of cancer. 14:30:38

24 Q. Okay. Do you feel that you have a specialized level 14:30:44

25 of knowledge beyond the general level of knowledge 14:30:54

1 in society that seems to acknowledge that cigarette 14:30:58

2 smoking is a factor in lung cancer? 14:31:02

3 A. Obviously, I see this correlation very strongly in 14:31:08

4 the population of patients that I treat. 14:31:10

5 Q. Okay. Have you systematically tried to compile 14:31:14

6 information regarding your treatment experience into 14:31:20

7 the compilation of some statistical association 14:31:34

8 between cigarette smoking and lung cancer? 14:31:34

9 A. No. 14:31:34

10 Q. Have you reviewed the scientific literature 14:31:38

11 specifically looking at epidemiological studies that 14:31:44

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12 have been conducted to determine the question of 14:31:48
13 whether there's an association between smoking and 14:31:52
14 lung cancer? 14:31:52
15 MR. ORENSTEIN: Objection; overbroad, 14:31:54
16 ambiguous.
17 THE WITNESS: You would have to be much 14:31:58
18 more specific with that question. 14:32:02
19 BY MR. KEMNA:
20 Q. Have you reviewed any epidemiological studies that 14:32:22
21 investigate the question of whether there's an 14:32:24
22 association between cigarette smoking and lung 14:32:26
23 cancer? 14:32:28
24 A. I have reviewed articles over the years that look at 14:32:44
25 the epidemiology of smoking among lung cancer 14:32:50

1 patients. These articles have not specifically 14:32:54
2 addressed just the epidemiology. 14:33:00
3 Articles such as those put out by the 14:33:02
4 American Cancer Society and in articles on the 14:33:06
5 treatment of lung cancer, it will frequently address 14:33:10
6 the epidemiology of the disease as part of the 14:33:16
7 articles that are written. 14:33:18
8 Q. Are you familiar with any of the major 14:33:34
9 epidemiological studies regarding smoking and lung 14:33:38
10 cancer that have been published? 14:33:40
11 MR. ORENSTEIN: Objection; ambiguous. 14:33:42
12 THE WITNESS: You would have to show me 14:33:46
13 the specific studies you were referring to. 14:33:48
14 BY MR. KEMNA:

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15 Q. Are you familiar with any study -- well, let me 14:33:58
16 rephrase the question. 14:33:58
17 Are you familiar with any of the lead 14:34:02
18 authors or any of the investigators for any 14:34:06
19 epidemiological study that's been conducted on 14:34:08
20 smoking and lung cancer? 14:34:10
21 A. No, not that I can think of. 14:34:14
22 Q. Have you ever reviewed the literature that deals 14:34:16
23 directly with the data compiled, and the findings 14:34:22
24 based upon that data, for epidemiological 14:34:24
25 investigation of cigarette smoking and lung cancer? 14:34:28

1 MR. ORENSTEIN: Objection; ambiguous. 14:34:30
2 THE WITNESS: Not that I can remember, as 14:34:34
3 far as how I understand the question. 14:34:36
4 BY MR. KEMNA:
5 Q. All right. Are you an expert in the field of 14:34:42
6 epidemiology? 14:34:44
7 A. No. 14:34:44
8 Q. Are you an expert in the field of statistics? 14:34:50
9 A. No. 14:34:50
10 Q. Are you an expert in the field of biostatistics? 14:34:52
11 A. No. 14:34:54
12 Q. Do you have the qualifications to interpret 14:35:02
13 statistical data compiled in epidemiological 14:35:08
14 studies? 14:35:08
15 MR. ORENSTEIN: Objection; ambiguous. 14:35:14
16 THE WITNESS: It would depend on how you 14:35:18

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17 mean to interpret that data. Do I understand that 14:35:26
18 there are certain levels that are significant in as 14:35:30
19 far as the statistics go and understand those 14:35:34
20 conclusions? The vast majority of the time, I would 14:35:40
21 say, yes, there are. 14:35:44
22 But can I analyze the statistical 14:35:46
23 analysis? No, that would have to be someone that 14:35:50
24 was an expert in statistical analysis. 14:35:54
25 BY MR. KEMNA:

1 Q. In expressing your view that smoking is a 14:36:02
2 contributing factor to lung cancer, do you mean to 14:36:10
3 imply that smoking has been established 14:36:12
4 scientifically as being in a cause and effect 14:36:20
5 relationship with lung cancer? 14:36:20
6 A. I think the Surgeon General's report and several 14:36:26
7 other reports have shown a significant correlation. 14:36:30
8 And I see that correlation among the patients that I 14:36:34
9 see. 14:36:34
10 Q. Okay. Try to answer the question that I pose. This 14:36:46
11 is a question geared to getting your opinion 14:36:48
12 regarding whether you are expressing an expert 14:36:54
13 opinion stating that a cause and effect relationship 14:36:58
14 has been established between cigarette smoking and 14:37:00
15 lung cancer. 14:37:04
16 Is that your conclusion? 14:37:06
17 A. I think you'd have to rely on the expert opinion of 14:37:10
18 an epidemiologist, if you are talking about an 14:37:12
19 expert in that area. 14:37:14

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20 Q. So you don't consider yourself to have the expertise 14:37:18
21 necessary to express an opinion on the question of 14:37:22
22 whether there is a cause and effect relationship 14:37:24
23 established between cigarette smoking and lung 14:37:26
24 cancer; is that correct? 14:37:28
25 A. I cannot interpret, as an expert, epidemiologic 14:37:38

1 information. That would have to be left to the 14:37:44
2 epidemiologist to discuss why they come to the 14:37:48
3 conclusions they come to. 14:37:52
4 As a medical oncologist, we rely on 14:37:56
5 articles that discuss the epidemiology in treatment 14:38:04
6 and follow-up of our lung cancer patients, but I am 14:38:08
7 not an epidemiologist. 14:38:10
8 Q. Let's step back from reference to other specialties 14:38:24
9 for a moment and get to the question of what kind of 14:38:30
10 evidence you require in order to make your 14:38:34
11 determination of whether some factor, whatever that 14:38:44
12 may be, is a contributing factor to a disease 14:38:48
13 process, such as lung cancer. 14:38:56
14 What criteria do you apply to evidence in 14:39:02
15 medicine or science, generally, to come to a 14:39:06
16 conclusion that a factor, whatever that may be, is a 14:39:12
17 contributing factor to disease? 14:39:14
18 MR. ORENSTEIN: Objection. 14:39:16
19 THE WITNESS: As an oncologist, we rely on 14:39:30
20 multiple studies that are done. Again, most of 14:39:38
21 those studies will have an epidemiologic portion of 14:39:44

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22 them looking at causation, risk factors and such. 14:39:50

23 Once we have seen a number of reports that 14:39:54

24 come to the same types of conclusions, we need to 14:40:00

25 rely on those. But as oncologists, we also do not 14:40:04

1 have the expertise to pick apart the conclusions 14:40:08

2 that the experts in epidemiology and statistics say 14:40:16

3 as far as their conclusions in those reports. 14:40:26

4 BY MR. KEMNA:

5 Q. Doctor, would you agree that statistics alone cannot 14:40:34

6 prove cause and effect? 14:40:36

7 MR. ORENSTEIN: Objection; overbroad. 14:40:40

8 THE WITNESS: I could not agree or 14:40:46

9 disagree with that statement. 14:40:46

10 BY MR. KEMNA:

11 Q. Do you require more than statistical information in 14:40:54

12 order to make some conclusion about whether some 14:40:56

13 factor may be a contributing factor to a chronic 14:41:02

14 disease process, such as lung cancer? 14:41:04

15 MR. ORENSTEIN: Objection; overbroad. 14:41:06

16 THE WITNESS: Could you ask that question 14:41:12

17 more specifically? 14:41:18

18 BY MR. KEMNA:

19 Q. Well, I think first we need to address the concept 14:41:20

20 of cause and effect relationships and what it is 14:41:24

21 that you require in order to get to the point of 14:41:28

22 concluding cause and effect. 14:41:32

23 So my question really relates to what 14:41:36

24 types of evidence do you need to see before you 14:41:40

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25 would conclude that some factor causes some disease, 14:41:52

1 a chronic disease, for instance? 14:41:52
2 MR. ORENSTEIN: I'm going to object. This 14:41:56
3 has been asked and answered a number of times in a 14:41:58
4 number of different ways. 14:42:00
5 BY MR. KEMNA:
6 Q. You can answer. 14:42:04
7 A. Going back to what I -- the comment I made 14:42:12
8 previously, that as a medical oncologist you look at 14:42:16
9 a number of reports, papers looking at whatever 14:42:20
10 disease the article is about, looking at the 14:42:32
11 epidemiologic and statistical analysis of those 14:42:34
12 reports, and you draw your conclusions not from a 14:42:40
13 solitary report but a number of independent reports 14:42:46
14 that basically come to the same conclusion. 14:42:50
15 And over the years, there have been many 14:42:52
16 reports that have shown this significant association 14:42:58
17 in this particular case with smoking and lung 14:43:02
18 cancer, and that is where the conclusions are drawn 14:43:08
19 from. 14:43:08
20 Q. So you can conclude, based upon your own criteria, 14:43:18
21 that there is a cause and effect relationship 14:43:20
22 between smoking and lung cancer by simply 14:43:24
23 identifying an association between smoking and lung 14:43:28
24 cancer; is that what you're saying? 14:43:30
25 MR. ORENSTEIN: Objection; 14:43:30

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1 mischaracterizes her testimony. 14:43:34
2 THE WITNESS: Would you restate that? 14:43:38
3 MR. KEMNA: Just to make sure it comes out 14:43:42
4 the same way the second time, let's have the court 14:43:46
5 reporter repeat the question. 14:43:48
6 (The requested portion read back.)
7 MR. ORENSTEIN: Same objection; 14:44:08
8 mischaracterizes her testimony. 14:44:10
9 THE WITNESS: I think that what you are 14:44:16
10 asking does not reflect that we are talking about 14:44:20
11 numerous studies that look at this issue and have 14:44:26
12 come to the same conclusion, and that I am relying 14:44:30
13 on those numerous studies over many years of 14:44:34
14 reviewing those. It is not a solitary item that 14:44:44
15 brings us to that conclusion. 14:44:48
16 BY MR. KEMNA:
17 Q. Okay. Let me see if I can take it a step further 14:44:54
18 and clarify. 14:44:56
19 Is establishing association between a 14:44:58
20 factor and disease to you the same as establishing 14:45:02
21 that there's a cause and effect relationship between 14:45:04
22 the factor and the disease? 14:45:06
23 MR. ORENSTEIN: Objection; lack of 14:45:10
24 foundation. 14:45:10
25 THE WITNESS: I think that you'd have 14:45:12

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1 to -- that sounds like a question that an 14:45:16
2 epidemiologist would have to answer to say how do 14:45:20
3 they set up studies looking at this after they've 14:45:24
4 seen an association. 14:45:24
5 So I don't feel that that is in my area of 14:45:28
6 expertise to answer how they come to that 14:45:30
7 conclusion. I can only respond to the conclusions 14:45:34
8 they come to. 14:45:34
9 BY MR. KEMNA:
10 Q. And so that's really an acknowledgment on your part 14:45:42
11 that you've seen these conclusions in the 14:45:44
12 literature, and you're just simply relying upon 14:45:46
13 someone else's assessment of the evidence underlying 14:45:50
14 the conclusion; is that accurate? 14:45:52
15 MR. ORENSTEIN: Objection; 14:45:56
16 mischaracterizes her testimony. 14:45:58
17 THE WITNESS: That I rely on multiple 14:46:04
18 studies with different individuals that have come to 14:46:08
19 the same conclusion, and that their conclusions seem 14:46:16
20 very consistent with what I see in clinical 14:46:20
21 practice. 14:46:20
22 BY MR. KEMNA:
23 Q. Okay. But you are not in a position to make an 14:46:24
24 independent assessment of the evidence to make your 14:46:28
25 own determination regarding the nature of that 14:46:32

1 evidence; is that correct? 14:46:34
2 A. That would be an epidemiologic and statistical 14:46:38

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3 expert that would need to do that. 14:46:40
4 Q. And not you? 14:46:42
5 A. And not me. 14:46:44
6 Q. Have you ever reviewed any literature relating to 14:46:50
7 the experimental study of cigarette smoke in 14:46:56
8 laboratory? 14:46:58
9 A. No. 14:46:58
10 Q. Are you aware of any findings arising from that type 14:47:04
11 of research in the laboratory? 14:47:04
12 MR. ORENSTEIN: Objection; overbroad, 14:47:08
13 ambiguous. 14:47:10
14 THE WITNESS: Can you restate that in a 14:47:14
15 more specific -- 14:47:16
16 BY MR. KEMNA:
17 Q. Well, let me state it this way: Have you ever come 14:47:26
18 across any information relating to the findings of 14:47:28
19 the study of cigarette smoke as tested in laboratory 14:47:34
20 animals? 14:47:34
21 MR. ORENSTEIN: Objection. 14:47:38
22 THE WITNESS: I cannot remember reading 14:47:40
23 any specific animal studies relating to this issue. 14:47:42
24 BY MR. KEMNA:
25 Q. Okay. In your reading of the medical literature, or 14:47:50

1 actually any scientific literature, have you come 14:47:56
2 across any references to the study of cigarette 14:47:58
3 smoke in the laboratory? 14:48:00
4 MR. ORENSTEIN: Objection; overbroad. 14:48:04
5 THE WITNESS: I think that would be 14:48:10

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6 difficult to answer with respect to a specific 14:48:20
7 report and what you mean by "in the laboratory." 14:48:26
8 BY MR. KEMNA:
9 Q. Have you ever reviewed any studies that relate to 14:48:32
10 the testing of cigarette smoke by inhalation in 14:48:36
11 laboratory animals toward the objective of 14:48:38
12 determining whether lung cancer can be produced in 14:48:44
13 the animals? 14:48:46
14 A. I've never read any specific study that I can 14:48:48
15 remember relating to that. 14:48:50
16 Q. Okay. Have you ever read any articles that refer to 14:48:52
17 that type of research and indicate the findings of 14:48:56
18 that type of research? 14:48:58
19 A. I can never remember reading any article 14:49:02
20 specifically directed at that. 14:49:04
21 Q. So it's fair to say you don't have any knowledge of 14:49:10
22 the testing of cigarette smoke by way of inhalation 14:49:12
23 in laboratory animals; is that correct? 14:49:14
24 A. That's correct. 14:49:16
25 Q. Dr. Bowers, do you know the subcellular mechanisms 14:49:30

1 for the causation of lung cancer? 14:49:32
2 A. No. 14:49:32
3 Q. Are the mechanisms for the causation of lung cancer 14:49:38
4 known? 14:49:38
5 MR. ORENSTEIN: Objection; lack of 14:49:40
6 foundation. 14:49:40
7 THE WITNESS: You would have to ask 14:49:42

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8 somebody that is doing that research. 14:49:44
9 BY MR. KEMNA:
10 Q. Okay. You have no basis for making comment on that 14:49:52
11 question one way or the other, is that what you're 14:49:54
12 telling me? 14:49:54
13 A. That's correct. I am not a bench researcher. 14:49:58
14 Q. Doctor, is lung cancer fairly described as a disease 14:50:28
15 or a group of diseases? 14:50:30
16 MR. ORENSTEIN: Objection. 14:50:32
17 THE WITNESS: Not all lung cancers are the 14:50:38
18 same, so you would have to say that it would be more 14:50:40
19 of a group of disease because there are subsets of 14:50:46
20 the disease. 14:50:46
21 BY MR. KEMNA:
22 Q. So if I heard that correctly, you say it is accurate 14:50:52
23 to describe lung cancer as a group of diseases; is 14:50:56
24 that accurate? 14:50:56
25 A. That's accurate. 14:50:58

1 Q. And within that subset, as you described it, of this 14:51:10
2 number of diseases, do all of those diseases have 14:51:14
3 the same etiology? 14:51:14
4 MR. ORENSTEIN: Objection; ambiguous. 14:51:18
5 THE WITNESS: You would have to ask an 14:51:20
6 epidemiologist about that. 14:51:24
7 BY MR. KEMNA:
8 Q. So you cannot offer an opinion on what may cause any 14:51:30
9 one particular disease within this group of diseases 14:51:34
10 known as lung cancer; is that correct? 14:51:36

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11 MR. ORENSTEIN: Objection; 14:51:36

12 mischaracterizes the testimony. 14:51:38

13 BY MR. KEMNA:

14 Q. You can answer. 14:51:42

15 A. Would you ask that question a little more -- in a 14:51:52

16 form that'a a little more succinct? I'm not sure 14:51:54

17 exactly what the question is. 14:51:56

18 Q. Okay. You've acknowledged in one of your answers 14:52:04

19 that it is accurate to refer to lung cancer as a 14:52:10

20 group of diseases. 14:52:14

21 Are you in a position to state an opinion 14:52:16

22 as to the cause of each one of the diseases in this 14:52:22

23 subset of lung cancer? 14:52:26

24 MR. ORENSTEIN: Objection; overbroad. 14:52:28

25 THE WITNESS: Again, I think that we are 14:52:40

1 talking about an epidemiologic process here looking 14:52:48

2 at the subtypes of lung cancer and how they -- what 14:52:54

3 the epidemiology would say with regard to each of 14:52:56

4 the subtypes. 14:52:58

5 BY MR. KEMNA:

6 Q. Do you know what the epidemiology says with regard 14:53:06

7 to all the subtypes of lung cancer? 14:53:08

8 A. I'm not an epidemiologist. 14:53:10

9 Q. Do you have a recognition of what has been reported 14:53:16

10 from the field of epidemiology regarding the cause 14:53:22

11 of the individual subtypes of lung cancer? 14:53:26

12 MR. ORENSTEIN: Objection; overbroad. 14:53:28

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13 THE WITNESS: With respect to what? What 14:53:36
14 factors? 14:53:36
15 BY MR. KEMNA:
16 Q. Any factors. Do you know what the cause of each of 14:53:46
17 the subtypes of lung cancer is? 14:53:48
18 A. Again -- 14:53:50
19 MR. ORENSTEIN: Objection. 14:53:50
20 THE WITNESS: In discussing a disease, we 14:53:54
21 need to talk about populations with the disease and 14:54:02
22 what is felt epidemiologically to be the cause and 14:54:08
23 effect. 14:54:08
24 BY MR. KEMNA:
25 Q. Correct. And findings are reported in the 14:54:16

1 literature from the field of epidemiology with 14:54:20
2 respect to conclusions drawn by other investigators 14:54:22
3 with respect to the subtypes of lung cancer and 14:54:26
4 factors that may be involved in the cause of each 14:54:30
5 one of those subtypes. 14:54:32
6 Do you know what those conclusions are 14:54:34
7 with respect to each cell type, each subtype of lung 14:54:40
8 cancer? 14:54:42
9 MR. ORENSTEIN: Objection; overbroad. 14:54:44
10 And, Counsel, any question that has two "with 14:54:48
11 respect to's" in it, I think is venturing into a lot 14:54:52
12 of legalese. 14:54:52
13 MR. KEMNA: Let me just say that with 14:54:56
14 whatever difficulty you may have in understanding 14:54:58
15 the question, you can interpose an objection as to 14:55:02

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16 form, but any further speaking objections I think 14:55:06
17 you well recognize are not part of the procedure 14:55:08
18 here. 14:55:08
19 So your objections are taken as necessary 14:55:14
20 for the record. The witness can interpret the 14:55:18
21 question for herself. 14:55:20
22 If she can answer, that's fine. If she 14:55:22
23 can't, we'll do as we have and we'll clarify. 14:55:26
24 BY MR. KEMNA:
25 Q. So can you answer the question as it was asked? 14:55:28

1 A. Again, as far as an expert opinion, you will need to 14:55:34
2 talk with an epidemiologist on the causation of the 14:55:40
3 various types of lung cancer. 14:55:44
4 As a practicing medical oncologist in my 14:55:48
5 clinical practice, in what I see clinically, 14:55:52
6 certainly cigarette smoking is a very prevalent 14:56:02
7 problem for a predisposing factor for our lung 14:56:08
8 cancer patients. 14:56:10
9 But as far as the specific numbers in 14:56:14
10 epidemiology, you will need to talk with the 14:56:16
11 epidemiologist who is the expert witness and not to 14:56:20
12 me with regards to that. I will not be able to 14:56:24
13 answer that question. 14:56:24
14 Q. Doctor, the line that I read you in the second full 14:56:46
15 paragraph of page 2 of the document entitled -- 14:56:52
16 well, actually I shouldn't refer to it as page 14:56:52
17 number 2, it's page number 3 -- of the document 14:56:54

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18 entitled, "Plaintiffs' Expert Report, Barbara J. 14:57:00
19 Bowers," indicates that you will be testifying 14:57:06
20 regarding lung cancer as an example of a disease 14:57:08
21 caused by cigarette smoking. 14:57:10
22 Is it your understanding that the scope of 14:57:14
23 your testimony is limited to discussing lung cancer 14:57:18
24 versus other types of diseases? 14:57:20
25 A. Correct. 14:57:22

1 Q. Doctor, what types of -- well, let's start this 14:57:38
2 way. As you've described it, lung cancer, what are 14:57:44
3 the cell types or the subtypes of lung cancer that 14:57:48
4 you've mentioned? 14:57:48
5 A. We tend to divide lung cancer into two major groups, 14:57:56
6 the small cell cancers of the lung and the nonsmall 14:58:00
7 cell cancers of the lung. 14:58:02
8 The reason that we do that is because the 14:58:04
9 workup and treatment of each of these two subgroups 14:58:10
10 is different. 14:58:10
11 Q. Okay. Is there another way of classifying the 14:58:24
12 subtypes of lung cancer beyond the division between 14:58:28
13 small cell and nonsmall cell lung cancer? 14:58:32
14 A. The nonsmall cell lung cancers are divided into 14:58:38
15 subgroups, such as adenocarcinoma, squama cell 14:58:46
16 carcinoma, undifferentiated carcinoma, large cell 14:58:50
17 carcinoma. 14:58:50
18 But since they are basically all treated 14:58:56
19 and worked up the same, as medical oncologists, we 14:59:00
20 tend to group those together. 14:59:02

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21 Q. You mentioned undifferentiated carcinoma and then 14:59:12
22 large cell carcinoma. Are those two distinct cell 14:59:16
23 types within the nonsmall cell category? 14:59:20
24 A. They can -- pathologically the report can come up as 14:59:28
25 a large cell carcinoma or an undifferentiated 14:59:34

1 nonsmall cell carcinoma of the lung. 14:59:38
2 And we will see those in our path reports 14:59:40
3 that we need to deal with and treat the patient 14:59:46
4 according to what the pathologist says the disease 14:59:48
5 is. 14:59:50
6 Q. If the pathologist says undifferentiated nonsmall 14:59:54
7 cell carcinoma, is that interpreted as a report that 15:00:00
8 really does not conclude the specific cell type of 15:00:02
9 the lung cancer? 15:00:04
10 A. Not necessarily. It may be that -- we know that it 15:00:12
11 is then not a small cell carcinoma, that it may just 15:00:18
12 be such an aggressive form of one of the other 15:00:22
13 cancers that they cannot just by visually looking at 15:00:28
14 the slide determine which cell type it is. 15:00:32
15 Sometimes they can proceed further and do 15:00:36
16 special stains on an undifferentiated cancer or do 15:00:42
17 electron microscopy and give us more information if 15:00:46
18 it is clinically relevant for us to have that 15:00:50
19 information. 15:00:52
20 Frequently, it is not and we do not pursue 15:00:54
21 that because it does not benefit the patient. 15:01:02
22 Q. Doctor, are there subtypes of lung cancer within the 15:01:14

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23 category known as adenocarcinoma? 15:01:18

24 A. As far as the differentiation of the adeno, there 15:01:28

25 may be a well-differentiated or 15:01:30

1 moderately-differentiated or poorly-differentiated 15:01:34

2 adeno. But, again, they are all adenocarcinoma, so 15:01:40

3 we do not specifically need to differentiate the 15:01:44

4 differentiation of the cell type for treatment or 15:01:50

5 workup. 15:01:50

6 Q. Okay. I understand that it may not be particularly 15:01:56

7 relevant to your practice to provide further 15:02:00

8 delineation of exactly the cell type of lung cancer 15:02:08

9 if you know whether it's a small cell or a nonsmall 15:02:10

10 cell. 15:02:12

11 But in terms of the pathological 15:02:16

12 classification of lung cancers, are there subtypes 15:02:22

13 within the type adenocarcinoma? 15:02:28

14 A. Basically what -- the differentiation that I have 15:02:36

15 just given you, would be the basic subtypes -- 15:02:38

16 Q. So it would be -- 15:02:42

17 A. -- that we deal with. 15:02:42

18 Q. -- the subtypes would be, within adenocarcinoma, 15:02:46

19 would be described in degrees of differentiation, as 15:02:48

20 you've mentioned? 15:02:50

21 A. At least as far as we see in clinical medicine. 15:02:52

22 Q. Doctor, are you familiar with a cell type known as 15:02:58

23 bronchioloalveolar carcinoma? 15:03:02

24 A. Yes. 15:03:04

25 Q. Isn't it true that bronchioloalveolar carcinoma is a 15:03:08

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1 subtype of adenocarcinoma? 15:03:12
2 A. That type of carcinoma is usually listed in its own 15:03:18
3 category when it is seen because it is a distinct 15:03:26
4 form of -- a fairly distinct form of cancer. So 15:03:30
5 ordinarily we would not see the term "adno" and then 15:03:34
6 "bronchioloalveolar" on our path reports. 15:03:38
7 Q. Do you know in terms of the nomenclature adopted 15:03:50
8 within the field of pathology whether the term 15:03:52
9 "bronchioloalveolar carcinoma" belongs within the 15:03:56
10 category of cancers known as adenocarcinomas? 15:04:00
11 A. You would have to ask a pathologist how they code 15:04:02
12 that. We don't code those as oncologists. So you'd 15:04:06
13 need to ask a pathologist how they code those. 15:04:08
14 Q. Does it make any difference to you whether a patient 15:04:12
15 of yours has a bronchioloalveolar carcinoma versus 15:04:22
16 something described as a well-differentiated 15:04:24
17 adenocarcinoma? 15:04:24
18 A. I will say basically not, depending -- because the 15:04:30
19 staging is more important than the specifics of that 15:04:38
20 distinction. 15:04:40
21 Q. Within the category of cancers referred to as small 15:04:58
22 cell carcinoma, are there subtypes of small cell 15:05:04
23 carcinoma of the lung? 15:05:06
24 A. Again, clinically we do lump them. There are 15:05:14
25 some -- have been some attempt at trying to 15:05:18

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1 delineate whether you had a large cell, small cell 15:05:22
2 combination. 15:05:24
3 Some people referring to oat cell in 15:05:30
4 various distinctions, but basically not being able 15:05:34
5 to show that any of those distinctions were very 15:05:38
6 helpful in the treatment of these patients or of the 15:05:44
7 prognosis. So as an oncologist, we really do not 15:05:48
8 subtype those. 15:05:48
9 Q. Okay. If you'll permit me to paraphrase, in your 15:05:56
10 field of clinical practice, a small cell is a small 15:06:00
11 cell; is that accurate? 15:06:02
12 MR. ORENSTEIN: Objection. 15:06:02
13 THE WITNESS: I think that's 15:06:12
14 oversimplifying it. It depends on the stage of the 15:06:16
15 cancer. 15:06:16
16 I mean, there's so many factors that have 15:06:20
17 to deal with how you treat a patient and such, but 15:06:26
18 as far as determining what the workup is going to be 15:06:30
19 and the ultimate treatment, the pathologic 15:06:36
20 distinction that may or may not appear on the path 15:06:40
21 report would not be an issue for us. 15:06:44
22 BY MR. KEMNA:
23 Q. Do you know of any other nomenclature for 15:06:54
24 classifying cancers that would encompass small cell 15:06:58
25 carcinoma of the lung, other than what you've 15:07:02

1 referred to as small cell or oat cell carcinoma? 15:07:04

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2 A. Neuroendocrine tumors of the lung would be another 15:07:10
3 subclassification. 15:07:14
4 Q. Okay. The term "neuroendocrine tumors of the lung" 15:07:20
5 would encompass what you have referred to as small 15:07:24
6 cell carcinoma? 15:07:26
7 MR. ORENSTEIN: Objection. 15:07:28
8 THE WITNESS: They would be in that 15:07:32
9 category. I'm not sure what you mean by 15:07:36
10 "encompass." 15:07:36
11 BY MR. KEMNA:
12 Q. Okay, that's fair. Are there any other cell types 15:07:48
13 of lung cancer that are included within the category 15:07:52
14 of neuroendocrine tumors of the lung besides small 15:07:58
15 cell carcinoma? 15:07:58
16 A. One type would be a carcinoid of the lung, which is 15:08:04
17 also a neuroendocrine tumor. 15:08:10
18 Q. Are there different types of carcinoid tumors? 15:08:14
19 A. There are carcinoids that are involved in other 15:08:18
20 organs, the small bowel being the most common. 15:08:24
21 Q. Okay. Let's limit it to diseases of the lung for 15:08:28
22 the time being. 15:08:28
23 Are there other types of carcinoid tumors 15:08:32
24 that can occur -- let me rephrase that. 15:08:38
25 Are there subtypes of carcinoid tumors 15:08:40

1 that can occur in the lung? 15:08:44
2 A. I'm not aware of any, quote, "subtypes" of carcinoid 15:08:48
3 tumors. 15:08:48

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4 Q. Are all carcinoid tumors malignant? 15:08:56
5 A. No, some are benign. 15:08:58
6 Q. In terms of nomenclature, how do you differentiate 15:09:04
7 between one or the other? 15:09:06
8 A. You'd have a -- they'd label it as a carcinoid and 15:09:16
9 pathologically try to characterize it as either a 15:09:20
10 benign or malignant carcinoid, but it is not always 15:09:24
11 possible to tell pathologically whether they are 15:09:28
12 benign or malignant. 15:09:30
13 So basically in many of these people, you 15:09:34
14 need to follow them clinically to see how the cancer 15:09:38
15 acts as to whether it is a benign or malignant 15:09:44
16 carcinoid. They are fairly rare tumors. 15:09:52
17 Q. Are you familiar with the designation of a 15:10:00
18 well-differentiated neuroendocrine carcinoma? 15:10:04
19 A. The low grade or benign carcinoids would definitely 15:10:14
20 be well-differentiated. 15:10:16
21 Q. Okay. So does that mean they're the same thing? 15:10:20
22 A. As far as in the clinical practice of oncology, we 15:10:30
23 would look at them as being similar or the same. We 15:10:34
24 would need to talk with our pathologist to say, "How 15:10:38
25 are you classifying this? Which category would you 15:10:42

1 put this in?" 15:10:44
2 Q. Are you familiar with the term "atypical 15:10:50
3 carcinoid"? 15:10:52
4 A. I'm familiar with the term, but, again, I would have 15:10:58
5 to ask the pathologist what they meant by that 15:11:04
6 terminology. 15:11:06

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7 And, again, pathologists have many ways of 15:11:10
8 looking at the material and making a determination 15:11:16
9 because there are many gray categories that they try 15:11:20
10 to fit it in, depending upon the list of 15:11:22
11 characteristics that they are looking at under the 15:11:26
12 microscope, and that's beyond my field of 15:11:28
13 expertise. 15:11:28
14 Q. Is the question of whether a lung tumor is 15:11:34
15 categorized as a well-differentiated neuroendocrine 15:11:40
16 carcinoma or an atypical carcinoid of treatment 15:11:44
17 significance to you? 15:11:46
18 A. Definitely in those situations, we would be strongly 15:11:52
19 considering this person as an operative candidate. 15:11:58
20 So clinically that would be important as an 15:12:02
21 oncologist. 15:12:02
22 Q. Is an atypical carcinoid a malignant tumor? 15:12:08
23 A. Not necessarily. But, again, it depends on its 15:12:16
24 behavior, because it's not always possible to tell 15:12:22
25 just from the biopsy how these cancers will behave. 15:12:24

1 Q. Is there another cell type known as intermediate 15:12:32
2 cell carcinoma of the lung? 15:12:34
3 A. That is not a terminology I'm familiar with. 15:12:38
4 Q. Does the category known as neuroendocrine carcinomas 15:12:50
5 of the lung encompass small cell carcinoma of the 15:12:54
6 lung? 15:12:54
7 A. I would have to ask a pathologist how they define 15:12:58
8 that category. 15:13:00

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9 Q. Why are these tumors known as neuroendocrine 15:13:08
10 carcinomas? 15:13:08
11 MR. ORENSTEIN: Objection; lack of 15:13:10
12 foundation. 15:13:12
13 THE WITNESS: Again, I think it would be 15:13:14
14 best to ask a pathologist as to how they define 15:13:18
15 these with their special stains and electron 15:13:22
16 microscopy and how they come to the conclusion that 15:13:26
17 these are of neuroendocrine origin. 15:13:30
18 BY MR. KEMNA:
19 Q. Do you have an opinion on whether cigarette smoking 15:13:42
20 has been established as a cause of atypical 15:13:46
21 carcinoid tumors of the lung? 15:13:46
22 A. I do not have an opinion. 15:13:48
23 Q. Do you have an opinion on whether cigarette smoking 15:13:58
24 is a cause of well-differentiated neuroendocrine 15:14:02
25 carcinomas of the lung? 15:14:04

1 A. I do not have an opinion. That would be in the 15:14:10
2 realm of an epidemiologic opinion, and I'm not an 15:14:14
3 epidemiologist. 15:14:14
4 Q. Do you have an opinion as to whether cigarette 15:14:24
5 smoking is a cause of bronchioloalveolar carcinoma 15:14:30
6 of the lung? 15:14:30
7 A. Again, that would have to -- I would have to rely on 15:14:36
8 the epidemiologic opinion on that cancer. 15:14:40
9 Q. Can you offer any opinion at this point on whether 15:14:44
10 there was a cause and effect relationship between 15:14:46
11 cigarette smoking and bronchioloalveolar carcinoma 15:14:50

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12 of the lung? 15:14:50

13 A. That would be -- I cannot offer an opinion. In my 15:15:02

14 clinical experience, I have seen bronchioloalveolar 15:15:06

15 carcinoma in patients that are not smokers. 15:15:10

16 Q. Do you know what proportion of all lung cancers are 15:15:20

17 composed of by the diagnosis bronchioloalveolar 15:15:26

18 carcinoma? 15:15:26

19 A. I do not know the number, no. 15:15:28

20 Q. What proportion of lung cancers, present day, are 15:15:38

21 accounted for by the cell type adenocarcinoma of the 15:15:42

22 lung? 15:15:42

23 MR. ORENSTEIN: Objection; lack of 15:15:44

24 foundation. 15:15:44

25 THE WITNESS: Again, you would have to 15:15:46

1 address that with the epidemiologist as far as the 15:15:50

2 numbers. I do not have the percentages as something 15:15:58

3 that is clinically relevant to me, and so I could 15:16:02

4 not tell you what the specific percentages are. 15:16:06

5 BY MR. KEMNA:

6 Q. Doctor, lung cancers present within the lungs of 15:16:22

7 your patients, anyone, in various locations within 15:16:28

8 the lung, don't they? Is that accurate? 15:16:32

9 A. Lung cancers can form anywhere within the lung, 15:16:36

10 yes. 15:16:36

11 Q. Is there a particular location within the lung where 15:16:50

12 tumors that you would associate with cigarette 15:16:52

13 smoking are expected to present? 15:16:54

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14 MR. ORENSTEIN: Objection; ambiguous. 15:17:00
15 THE WITNESS: Again, with, you know, 15:17:06
16 looking at an epidemiologic report, they may have 15:17:10
17 statistics on where you would expect to find a given 15:17:16
18 cancer. 15:17:20
19 As an oncologist, we see the patient after 15:17:22
20 they are diagnosed. It is not -- we are not in the 15:17:26
21 business of diagnosing cancer. We're not in the 15:17:32
22 business of looking at x-rays and speculating on 15:17:36
23 what is seen on that x-ray. 15:17:44
24 So it's not, again, information that is 15:17:48
25 clinically relevant to our practice. 15:17:50

1 BY MR. KEMNA:
2 Q. So it's fair to say you're not in the business of 15:17:56
3 attempting to determine the cause of lung cancers in 15:17:58
4 the patients that you treat; is that accurate? 15:18:02
5 A. I'm in the business of staging and treating the 15:18:06
6 patient once they have been diagnosed with cancer, 15:18:14
7 and dealing with the problems thereof. 15:18:18
8 Q. But not determining the cause of the cancer; is that 15:18:22
9 correct?
10 A. I'm not a researcher looking at the cause of their 15:18:26
11 cancer, no. 15:18:26
12 MR. KEMNA: Let's go off the record. 15:18:32
13 THE VIDEOGRAPHER: We're off the video 15:18:34
14 record. The time is 3:18. This concludes tape 1 of 15:18:40
15 the deposition of Dr. Barbara Bowers. 15:18:44
16 (Off the record.) 15:18:46

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17 THE VIDEOGRAPHER: We're back on the video 15:29:20
18 record. This is tape 2 of the deposition of 15:29:22
19 Dr. Barbara Bowers. The time is 3:29 p.m. 15:29:28
20 BY MR. KEMNA:
21 Q. Doctor, are you familiar with the term "bronchogenic 15:29:44
22 carcinoma"? 15:29:44
23 A. Yes. 15:29:46
24 Q. What's the definition of the term "bronchogenic 15:29:50
25 carcinoma"? 15:29:52

1 MR. ORENSTEIN: Objection. 15:29:56
2 THE WITNESS: I'm not sure that I can give 15:30:00
3 you the textbook definition. We think of it in the 15:30:06
4 category of a nonsmall cell cancer, so you'd have to 15:30:12
5 look up the textbook definition of it. 15:30:16
6 BY MR. KEMNA:
7 Q. But you think of it as a nonsmall cell? 15:30:20
8 A. Well, we think of it as a, you know, a cancer of the 15:30:22
9 lung. And most of the bronchogenic carcinomas we 15:30:30
10 see are squama cell or, you know, we tend to use 15:30:34
11 that term in our conversation in that category. 15:30:38
12 But technically speaking, I suppose, any 15:30:40
13 lung cancer could be a bronchogenic carcinoma in a 15:30:44
14 broader sense. So you'd have to look up the 15:30:48
15 definition to get the exact definition of that 15:30:54
16 term. 15:30:54
17 Q. Does it make any difference to your treatment of a 15:31:04
18 patient as to whether you have a centrally located 15:31:08

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19 versus a peripherally located lung cancer? 15:31:12

20 MR. ORENSTEIN: Objection. 15:31:14

21 THE WITNESS: In the workup of a lung 15:31:18

22 cancer patient, one of the questions that you need 15:31:22

23 to ask is: Is this cancer a resectable cancer? 15:31:32

24 Centrally located cancers of the nonsmall cell type 15:31:36

25 are more difficult to resect than peripheral 15:31:42

1 lesions, with all other factors being equal. 15:31:48

2 But it is just one of the factors that 15:31:52

3 goes into determining whether a lung cancer patient 15:31:56

4 is resectable. 15:32:00

5 BY MR. KEMNA:

6 Q. What is included within the category of what you 15:32:16

7 would describe as centrally located cancers of the 15:32:22

8 lung? 15:32:22

9 A. You're going to have to restate that. Do you mean 15:32:34

10 where is the cancer located to make it a centrally 15:32:36

11 located cancer? 15:32:38

12 Q. I'll take that rephrasing, sure, if you could 15:32:42

13 provide me with that description. 15:32:44

14 A. Most of us feel that a centrally located cancer 15:32:50

15 would be within -- certainly within 50 to 60 percent 15:32:58

16 of -- from the midline, in other words, near the 15:33:02

17 structure such as the lymph nodes, the aorta, and 15:33:08

18 not out toward the periphery of the lung where 15:33:10

19 you're away from some of the vascular structures and 15:33:14

20 lymph nodes. 15:33:14

21 Q. Okay. Is a central location for a cancer 15:33:22

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22 necessarily connected with the major airways of the 15:33:30
23 lung? 15:33:30
24 A. I don't know exactly what you mean by "connected." 15:33:38
25 It's closer to the bigger -- the airways of the lung 15:33:42

1 get progressively smaller as they go out toward the 15:33:46
2 periphery. 15:33:48
3 So the further out you are, the smaller 15:33:50
4 the airways are. But you do not have to have a 15:33:54
5 centrally located lesion that is involved within the 15:34:00
6 larger airways or obstructing the larger airways. 15:34:06
7 You can have instances where the cancer is 15:34:10
8 within the lung parenchyma and small enough that 15:34:16
9 it's not creating problems with the large airways. 15:34:18
10 So I don't know if that answers your question or 15:34:20
11 not. 15:34:20
12 Q. You're aware of the term "endobronchial 15:34:26
13 presentation"? 15:34:26
14 A. Yes. 15:34:26
15 Q. Okay. Is a centrally located cancer necessarily 15:34:30
16 endobronchial? 15:34:32
17 A. No, it is not necessarily endobronchial. And you 15:34:38
18 may actually see some of the more peripheral lesions 15:34:44
19 that are still within the bronchus and starting to 15:34:48
20 spread out. 15:34:52
21 I think that you tend to see more 15:34:54
22 centrally located lesions that are in the bronchial 15:34:56
23 in creating obstruction of the large airways and 15:35:02

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24 changes in the lung peripheral to that. 15:35:04

25 Q. You've attempted to provide, I think, a description 15:35:12

1 of a central location within the lung. Any 15:35:18

2 presentation of a cancer outside of that region you 15:35:24

3 described as central, I take it, would be described 15:35:26

4 as a peripherally located cancer; is that accurate? 15:35:30

5 A. Or more peripherally located. I mean, again, we 15:35:34

6 split hairs, but again as far as the looking at 15:35:38

7 whether something is more easily resectable, for us 15:35:46

8 a tumor that is further out in the periphery is 15:35:52

9 significantly -- is a significant issue when we're 15:35:58

10 looking at the possibility of resecting. 15:36:02

11 Q. Doctor, do you have an opinion regarding whether 15:36:08

12 peripherally located cancers of the lung are caused 15:36:14

13 by cigarette smoking? 15:36:16

14 A. I do not have an opinion on that. Again, we'd have 15:36:24

15 to look at what the epidemiologic studies show. I 15:36:32

16 don't know that they are less likely to be produced 15:36:38

17 by smoking or more likely epidemiologically. And 15:36:44

18 doctor -- an epidemiologist such as Dr. Samet could 15:36:48

19 probably put numbers to that question. 15:36:50

20 Q. Do you know whether Dr. Samet has put numbers to 15:36:56

21 that question? 15:36:56

22 A. I do not know. 15:36:58

23 Q. Now, we've talked about a number of the major cell 15:37:14

24 types of lung cancer and subtypes of lung cancer. 15:37:20

25 Beyond those we've already addressed, are there any 15:37:24

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other types of carcinoma that occur within the 15:37:28
lung? 15:37:28
A. You mean such as metastatic carcinomas? 15:37:40
Q. Well, we'll discuss those in just a moment. But 15:37:44
apart from metastatic lesions to the lung, are there 15:37:48
any other types of carcinoma that occur within the 15:37:52
lung as a primary lesion? 15:37:56
A. Well, you have your mesotheliomas which form within 15:38:02
the lining of the lung, and I'm not sure if that is 15:38:08
what you're referring to. 15:38:08
Q. Is a mesothelioma generally regarded as a lung 15:38:16
cancer? 15:38:16
A. Because it involves the pleura of the lung, as a 15:38:30
medical oncologist, yes, mesothelioma of the lung is 15:38:34
considered a lung cancer. 15:38:34
Q. Okay. So when one speaks of a pathological 15:38:44
classification of cancers of the lung, mesothelioma 15:38:48
would be one of them; is that correct? 15:38:50
MR. ORENSTEIN: Objection. 15:38:54
THE WITNESS: Technically speaking, I 15:38:58
would have to say that that probably would be 15:39:02
considered the case. Although, clinically, we look 15:39:12
at them so differently that we actually subclassify 15:39:12
them in our textbooks separately in most instances. 15:39:12
So in our mind set, we do think of 15:39:14

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1 mesotheliomas as being somewhat different because 15:39:20
2 they are on the pleura and not of the parenchyma of 15:39:24
3 the lung tissue. 15:39:26
4 BY MR. KEMNA:
5 Q. Has mesotheliomas been connected with cigarette 15:39:42
6 smoking as a possible etiological factor? 15:39:46
7 MR. ORENSTEIN: Objection; ambiguous, 15:39:48
8 vague. 15:39:48
9 BY MR. KEMNA:
10 Q. You can answer. 15:39:48
11 A. In our literature, there are articles that talk 15:40:02
12 about association with cigarette smoking and other 15:40:06
13 causes associated with mesothelioma. What the 15:40:10
14 epidemiologic association is, however, I cannot 15:40:16
15 answer. 15:40:16
16 Q. Okay. So what you're saying is that in reviewing 15:40:22
17 the literature, you've seen reference to cigarette 15:40:24
18 smoking as a possible causative factor in 15:40:26
19 mesothelioma; is that correct? 15:40:28
20 MR. ORENSTEIN: Objection. 15:40:30
21 THE WITNESS: I would, again, have to look 15:40:32
22 at the epidemiologic studies addressing that issue. 15:40:36
23 But the comment has been made as a potential 15:40:40
24 significant contributing factor, but how that is 15:40:48
25 supported epidemiologically, I am not prepared to 15:40:50

1 answer. 15:40:50
2 BY MR. KEMNA:

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3 Q. Is mesothelioma a form of carcinoma? 15:41:06
4 A. Since it's a cancer on the lining of the lung, it 15:41:32
5 has -- I believe pathologically it would be in the 15:41:38
6 realm of a carcinoma, but there are other histologic 15:41:52
7 characterizations because of the subtype, and you'd 15:41:58
8 have to ask a pathologist if they can technically 15:42:02
9 classify it as a carcinoma. 15:42:04
10 It is treated slightly different than the 15:42:08
11 other nonsmall cells and staged differently than 15:42:16
12 they are, too. So, again, we look at it as a 15:42:18
13 separate category of diseases. 15:42:20
14 Q. The question of whether a particular type of cancer 15:42:38
15 falls within the category of carcinoma relates to 15:42:46
16 what distinguishing factor regarding its 15:42:52
17 presentation? 15:42:52
18 MR. ORENSTEIN: Objection. 15:42:56
19 THE WITNESS: I don't know that it has any 15:43:00
20 -- I think that what I am thinking of is, you know, 15:43:04
21 whether it has some relationship to the sarcomas or 15:43:08
22 connective tissue. 15:43:10
23 But the mesotheliomas have some 15:43:14
24 thronged-like characteristics pathologically that 15:43:18
25 most of us think more on the lines of carcinoma, so 15:43:22

1 you would, again, to get the specific biochemical 15:43:26
2 and/or electron microscopy distinction, you would 15:43:32
3 need to ask a pathologist. 15:43:38
4 BY MR. KEMNA:

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5 Q. Well, let me ask you this way: To determine whether 15:43:48
6 you're dealing with a carcinoma or a sarcoma, does 15:43:56
7 it depend upon what type of tissue that the cancer 15:43:58
8 is actually developing in? 15:44:00
9 A. From. 15:44:04
10 Q. From? 15:44:08
11 A. From. 15:44:08
12 Q. And your answer? 15:44:10
13 A. Sarcomas are developed from fibroconnective tissue. 15:44:22
14 Carcinomas are from the parenchymal portion of an 15:44:30
15 organ. 15:44:30
16 Q. Do sarcomas present as primary cancers within the 15:44:48
17 lung? 15:44:48
18 A. You can -- you have fibroconnective tissue within 15:44:56
19 the lung, and, thus, it would be possible to have a 15:45:02
20 sarcoma develop in that fibroconnective tissue. 15:45:08
21 Q. Have sarcomas that present as primary cancers of the 15:45:26
22 lung been connected with cigarette smoking as a 15:45:30
23 possible etiological factor? 15:45:32
24 MR. ORENSTEIN: Objection; vague. 15:45:34
25 THE WITNESS: Again, they would be 15:45:38

1 incredibly rare, and I would not be prepared to 15:45:40
2 discuss their etiology in any manner at all. 15:45:50
3 BY MR. KEMNA:
4 Q. Doctor, do lymphomas occur within the lung? 15:46:04
5 A. There's lymphoid tissue within the mediastinum. 15:46:10
6 There's lymph vessels and lymph tissue throughout 15:46:14
7 the whole body, including the lung. 15:46:18

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8 And you can get lymphomas that -- 15:46:22
9 lymphomatous masses that are present in those lymph 15:46:28
10 node or lymphoid tissue anywhere in the body. And 15:46:34
11 lung is not excluded from that. 15:46:36
12 Q. Do you have an opinion whether lymphomas have been 15:46:42
13 connected with cigarette smoking as a possible 15:46:44
14 etiological factor? 15:46:46
15 MR. ORENSTEIN: Objection. 15:46:48
16 THE WITNESS: You need to address that 15:46:50
17 with an epidemiologist, such as Dr. Samet. I am not 15:46:56
18 prepared to answer that. 15:46:58
19 BY MR. KEMNA:
20 Q. Any other types of cancers that can occur as a 15:47:10
21 primary cancer within the lung, besides the 15:47:16
22 metastatic lesions that you referred to? 15:47:24
23 A. There are tumors that can occur anywhere within -- 15:47:28
24 in the body, the chest or the abdomen, such as 15:47:32
25 dermoids, that can be malignant or benign. 15:47:40

1 That would be the only other one that 15:47:42
2 would come to mind right at this moment. 15:47:44
3 Q. Are you familiar with a cancer called mucoepidermoid 15:47:52
4 carcinoma? 15:47:52
5 A. I've never seen one of those cases, but I do know 15:47:58
6 they exist, yes. 15:48:00
7 Q. Do they occur -- can they occur as a primary lesion 15:48:06
8 in the lung? 15:48:06
9 A. I believe so. 15:48:08

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10 Q. Do you have an opinion regarding whether 15:48:14
11 mucoepidermoid carcinomas of the lung have been 15:48:20
12 connected as a possible etiological factor with 15:48:26
13 cigarette smoking? 15:48:26
14 A. No, I do not. 15:48:26
15 MR. ORENSTEIN: Objection. 15:48:26
16 BY MR. KEMNA:
17 Q. Let me rephrase the question. Do you have an 15:48:32
18 opinion regarding whether mucoepidermoid carcinoma 15:48:34
19 has been connected with cigarette smoking as a 15:48:38
20 possible etiological factor? 15:48:40
21 A. No, I do not have an opinion. 15:48:42
22 Q. Now, Doctor, you referred earlier in your testimony 15:48:48
23 to metastatic cancers of the lung. From what other 15:49:00
24 parts of the body can cancers metastasize to the 15:49:06
25 lung? 15:49:08

1 A. Virtually every part of the body, except the brain, 15:49:14
2 for the most part. And even in pediatrics some of 15:49:18
3 their tumors can, but primary brain cancers do not, 15:49:24
4 in adults, do not usually metastasize to the lung. 15:49:28
5 But virtually every other cancer can metastasize in 15:49:36
6 some situations. 15:49:36
7 Q. Can a squama cell cancer of the skin metastasize to 15:50:04
8 the lung? 15:50:04
9 A. It can. It's quite rare to see any of the skin 15:50:08
10 cancers -- to see either squama cell or basal cell 15:50:14
11 metastasize at all. But is it possible? It is 15:50:24
12 possible that since they are cancer and can spread 15:50:28

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13 that they could do that. Have I ever seen it? No. 15:50:32
14 Q. You'd agree, wouldn't you, Doctor, that malignant 15:50:42
15 melanoma is a skin cancer? 15:50:46
16 A. Yes. And that's why I separated that from the basal 15:50:48
17 cell and squama cell as being the more common cancer 15:50:54
18 to metastasize. 15:50:56
19 Q. So malignant melanoma is a more common cancer to 15:51:00
20 metastasize. Does it metastasize to the lung? 15:51:04
21 A. Yes. 15:51:06
22 Q. Is it common for a malignant melanoma to metastasize 15:51:10
23 to the lung? 15:51:10
24 A. Yes. 15:51:10
25 Q. Do you know whether based on its histological 15:51:22

1 appearance that a metastatic malignant melanoma to 15:51:28
2 the lung could be confused with a primary cancer of 15:51:30
3 the lung? 15:51:30
4 A. There are biochemical and electron microscopic 15:51:40
5 distinctions that the pathologists use to 15:51:46
6 distinguish something as a melanoma. 15:51:56
7 Q. Can breast cancer metastasize to the lung? 15:52:10
8 A. Yes. 15:52:12
9 Q. Is it common to observe metatheses to the lung from 15:52:18
10 breast cancer? 15:52:20
11 A. Yes. 15:52:20
12 Q. Do you know whether histologically it's possible to 15:52:28
13 confuse a malignant metastatic breast cancer lesion 15:52:36
14 to the lung with those cancers that are typically 15:52:40

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15 thought of as primary cancers of the lung? 15:52:44

16 MR. ORENSTEIN: Objection. 15:52:44

17 THE WITNESS: You were talking 15:52:46

18 histologically, is that what you said? 15:52:48

19 BY MR. KEMNA:

20 Q. Yes. 15:52:50

21 A. You would have to ask a pathologist what degree of 15:52:56

22 difficulty it is to distinguish -- pathologically 15:53:02

23 have that distinction. 15:53:06

24 Q. Do you, as a clinician in the field of oncology, 15:53:10

25 sometimes have difficulty distinguishing whether a 15:53:16

1 cancer is, in fact, a primary cancer to the lung or 15:53:20

2 is metastatic to the lung from some other location 15:53:24

3 in the body? 15:53:24

4 A. That is a question that we ask when we see a patient 15:53:34

5 with a lung lesion. And we do try to make that 15:53:40

6 distinction with evaluation and the help of our 15:53:46

7 pathologists. 15:53:46

8 Q. What types of procedures can you conduct as an 15:53:56

9 oncologist to provide for some clarification 15:54:02

10 regarding whether a cancer is primary versus 15:54:08

11 metastatic to the lung? 15:54:10

12 A. The first thing that we'd look at is the pathology 15:54:20

13 report. The patient will come to us with a 15:54:26

14 pathology report that helps us determine the type of 15:54:30

15 cancer that we are dealing with. 15:54:34

16 Sometimes they are very helpful with the 15:54:38

17 various markers that they do and special stains, 15:54:44

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18 electron microscopy, and various tools at their 15:54:50
19 disposal to distinguish where this cancer has come 15:54:54
20 from. 15:54:54
21 Also sometimes the pattern that the cancer 15:54:56
22 has, whether there's a solitary lesion, multiple 15:55:00
23 lesions. And then other problems that the patient 15:55:06
24 may have, whether they have a breast lump or they 15:55:10
25 have a tumor somewhere else in their body, such as 15:55:16

1 in their G.I. tract or kidney or other organ system, 15:55:22
2 we would, as part of the workup and staging of the 15:55:26
3 patient, we would look at their other organ systems 15:55:30
4 to see if we have a distinction as to where the 15:55:36
5 cancer's coming from. 15:55:38
6 Q. Doctor, do you find that frequently the pathology 15:55:48
7 workup on your patients results in simply a 15:55:56
8 diagnosis or attempted diagnosis by light 15:56:02
9 microscopic view of biopsy and cytology specimens? 15:56:10
10 MR. ORENSTEIN: Objection. 15:56:12
11 THE WITNESS: Can you read that question 15:56:16
12 again? 15:56:18
13 (The requested portion read back.) 15:56:18
14 MR. ORENSTEIN: Objection; compound 15:56:40
15 question, overbroad. 15:56:42
16 THE WITNESS: I guess I would have some 15:56:46
17 concern over the term "frequently." I think you 15:56:52
18 would have to ask the pathologist how frequently 15:56:54
19 they rely just on light microscopy. 15:57:00

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20 I think we are more used to seeing special 15:57:02
21 stains and other data in our path reports, but the 15:57:10
22 term "frequently" means that most of the time it is 15:57:14
23 just light microscopy and I have no idea what the 15:57:20
24 percentage of our patients they're dealing with just 15:57:24
25 light microscopy as opposed to other tools that they 15:57:28

1 may use. 15:57:28
2 BY MR. KEMNA:
3 Q. You would agree, wouldn't you, Doctor, that it's not 15:57:40
4 uncommon to encounter patients that have had 15:57:44
5 diagnostic workup, but it has not been determined 15:57:46
6 whether the cancer is, in fact, primary versus 15:57:52
7 metastatic to the lung? 15:57:52
8 A. You used the term "uncommon." I do not -- I 15:58:08
9 certainly do not think that that is anywhere near a 15:58:12
10 common scenario these days. 15:58:16
11 I think that at least in my practice here 15:58:24
12 in Minneapolis that that is a much -- we see it, but 15:58:34
13 it's fairly uncommon to see a situation where we're 15:58:40
14 having some problems with distinguishing a primary 15:58:46
15 lung cancer from a metastatic cancer. 15:58:52
16 So I would think it would be basically 15:58:54
17 more likely to be stated uncommon for us to see 15:58:58
18 that. But can it happen? Yes. 15:59:02
19 Q. And you've seen it? 15:59:02
20 A. And I have seen it. 15:59:04
21 Q. Let's take the example of breast cancer. You'd 15:59:08
22 agree, wouldn't you, Doctor, that breast cancer can 15:59:12

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23 metastasize anywhere from weeks, months, to decades 15:59:22
24 after the primary cancer has presented; is that 15:59:26
25 accurate? 15:59:26

1 MR. ORENSTEIN: Objection. 15:59:26
2 THE WITNESS: It's in the literature, 15:59:32
3 yes. 15:59:32
4 BY MR. KEMNA:
5 Q. Let's say in a patient that had primary cancer of 15:59:44
6 the breast and presented, let's say, six years later 15:59:54
7 with an endobronchial presentation of cancer in the 16:00:00
8 lung. 16:00:04
9 What would you look for in attempting to 16:00:06
10 define whether that cancer is a primary cancer of 16:00:10
11 the lung or a metastases from the breast? 16:00:14
12 A. Well, I would want the pathologists to do their 16:00:20
13 battery of studies looking to see if they can 16:00:26
14 distinguish origin. 16:00:28
15 They would also -- I would also want them 16:00:32
16 to review the original pathology of the breast 16:00:38
17 cancer to see if there were similarities, if these 16:00:44
18 cancers looked similar under the microscope. 16:00:52
19 Obviously looking for other areas of 16:00:56
20 metastases, which would help distinguish this as a 16:01:04
21 metastatic cancer looking at the areas such as lymph 16:01:10
22 nodes and bone, lung, liver, other areas of the 16:01:16
23 lung, because most metastases will ultimately be in 16:01:20
24 more than one location by virtue of the term 16:01:28

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25 metastases and how they spread. 16:01:30

1 Q. It's also true that primary cancers of the lung can 16:01:36
2 metastasize themselves to locations common to the 16:01:38
3 locations for breast metastases; isn't that 16:01:42
4 correct? 16:01:42
5 A. That's true. 16:01:42
6 Q. Let's further define our example to establish that 16:01:52
7 you have an endobronchial presentation of a cancer 16:01:56
8 that appears to be nonsmall cell and that it is, in 16:02:04
9 fact, a solitary pulmonary nodule. 16:02:12
10 Do you have a basis for making a 16:02:14
11 determination of whether that's a primary or a 16:02:16
12 metastatic lesion? 16:02:20
13 MR. ORENSTEIN: Objection. 16:02:20
14 THE WITNESS: You know, again, we're 16:02:22
15 talking about one case, and it's hard without having 16:02:28
16 all of the data on that one case, you know, as a 16:02:32
17 supposition because there's so many potential 16:02:34
18 possibilities and so many questions that you would 16:02:40
19 ask and look at the whole picture that it's not, 16:02:44
20 it's not really an accurate -- I can't give an 16:02:48
21 accurate answer, you know, yes or no. 16:02:50
22 There are just too many factors that are 16:02:52
23 involved in the workup of that patient. 16:02:54
24 BY MR. KEMNA:
25 Q. Okay. So, what you're saying is that in those types 16:02:56

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of instances where you're attempting to 16:02:58
differentiate between a primary and metastatic 16:03:02
lesion, you really do need to examine quite a number 16:03:08
of factors in the presentation of the disease in 16:03:10
order to make some kind of a judgment as to whether 16:03:14
it is indeed primary or metastatic, would that be 16:03:16
accurate? 16:03:16
MR. ORENSTEIN: Objection. 16:03:18
THE WITNESS: That would be what we would 16:03:20
proceed to do in the workup of a patient, yes. 16:03:24
BY MR. KEMNA:
Q. Doctor, would you agree that the most common type of 16:03:52
cancer presenting in the lungs is a cancer 16:04:00
metastatic to the lung? 16:04:02
MR. ORENSTEIN: Objection; lack of 16:04:04
foundation. 16:04:04
THE WITNESS: I would have to look at what 16:04:08
you meant by presenting and look at the data. I'm 16:04:16
not prepared to answer that question. 16:04:18
BY MR. KEMNA:
Q. Doctor, I think you've indicated in your testimony 16:05:12
today that you really see patients for the most part 16:05:24
by referral from other physicians; is that 16:05:26
accurate? 16:05:26
A. That's accurate. 16:05:28

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1 Q. And that by the time these patients make their way 16:05:34
2 to your office, the diagnosis has been made, in 16:05:40
3 large part; is that accurate? 16:05:42
4 MR. ORENSTEIN: Objection; 16:05:44
5 mischaracterizes the testimony. 16:05:46
6 THE WITNESS: By the time they reach our 16:05:52
7 office, the diagnosis of cancer has been made, 16:06:00
8 depending upon what the referral source is, any 16:06:10
9 other workup may or may not have been done. 16:06:12
10 BY MR. KEMNA:
11 Q. With respect to cancers that -- excuse me, let me 16:06:32
12 rephrase that. 16:06:34
13 With respect to patients that have been -- 16:06:44
14 that are referred to your office to deal with the 16:06:46
15 treatment of lung cancer, they've been diagnosed 16:06:52
16 with lung cancer before they make their way to you; 16:06:56
17 is that accurate? 16:06:56
18 A. I think that would be an accurate statement. 16:07:02
19 Q. Do you end up treating patients for lung cancer by 16:07:06
20 referral that have not previously been diagnosed as 16:07:10
21 having lung cancer? 16:07:10
22 A. I'm sorry, that portion of the question I do not 16:07:16
23 understand. 16:07:16
24 Q. Okay. 16:07:18
25 A. They do not usually come to our office without a 16:07:20

1 diagnosis. Is that what you're referring to? 16:07:24
2 Q. Maybe. Let me give you another question. You see 16:07:36
3 most of your patients by referral. You've already 16:07:40

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4 indicated that, in large part, they arrive at your 16:07:46
5 office with a diagnosis of lung cancer if you're 16:07:48
6 going to treat them for lung cancer. 16:07:52
7 Do you have patients that you have a 16:07:58
8 referral from another physician to treat lung cancer 16:08:00
9 when they haven't been previously diagnosed with 16:08:02
10 lung cancer? 16:08:04
11 MR. ORENSTEIN: Objection. 16:08:04
12 THE WITNESS: Again, I'm struggling to see 16:08:20
13 what type of patient you're talking about and the 16:08:24
14 scenario that you are talking about and try to 16:08:28
15 figure out what this patient is coming in for if 16:08:32
16 they have not a diagnosis of cancer. 16:08:34
17 BY MR. KEMNA:
18 Q. Okay. Well, I think you're probably saying perhaps 16:08:38
19 the point of my question. But let me see if I can 16:08:40
20 be more direct with it. 16:08:42
21 Patients that are referred to you from 16:08:46
22 other physicians for treatment, do you find yourself 16:08:50
23 in the position of being the first doctor that 16:08:56
24 actually makes the diagnosis of lung cancer in those 16:08:58
25 patients? 16:09:00

1 MR. ORENSTEIN: Objection; overbroad. 16:09:04
2 THE WITNESS: Again, I think that a 16:09:16
3 patient that came to our office would have had 16:09:22
4 pathologic evidence of a malignancy. 16:09:30
5 There may be because of the workup that we 16:09:36

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6 do for staging them, we may be the people, the 16:09:44
7 doctors that establish that indeed this is a lung 16:09:48
8 cancer to help the patient understand where their 16:09:52
9 cancer originated from. 16:09:58
10 But the patient would know that they had a 16:10:02
11 malignancy and that they had a lung abnormality and 16:10:06
12 probably referred to that as a lung cancer in their 16:10:10
13 mind and someone would have probably used that 16:10:14
14 terminology before they came in. 16:10:16
15 So I'm not sure exactly, again, where 16:10:20
16 you're getting at with that questioning. 16:10:22
17 Q. Okay. I think you've answered the question. Do you 16:10:36
18 see any patients that aren't by referral from 16:10:38
19 another physician? 16:10:38
20 A. Basically I would have to say no because they've all 16:10:54
21 had to have a pathologic diagnosis to get into our 16:11:00
22 office, and we have referring physicians that either 16:11:10
23 are -- such as a case may be that somebody is coming 16:11:16
24 from out of state and needs an oncologist. 16:11:18
25 We may not actually talk to the original 16:11:22

1 doctor, but the doctor has said follow-up with this 16:11:26
2 office. It's still a referral and we still like to 16:11:32
3 get records back and forth, but for our cancer 16:11:36
4 patients, they've all basically had to have -- be in 16:11:40
5 touch with another doctor to get into the system 16:11:44
6 with their cancer. 16:11:46
7 Q. Doctor, if a patient comes into your office without 16:12:18
8 benefit of seeing a copy of all their medical 16:12:24

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9 records of treatment prior to seeing you, they 16:12:28
10 indicate to you that they feel they're in a poor 16:12:34
11 state of health, can you undertake a treatment 16:12:40
12 regimen for such a patient? 16:12:44
13 MR. ORENSTEIN: Objection. 16:12:44
14 THE WITNESS: I have a hard time 16:12:50
15 imagining, again, what case scenario this would be 16:12:56
16 in an oncologists' office. 16:12:58
17 BY MR. KEMNA:
18 Q. Okay. What do you need to know about that patient 16:13:04
19 before you can begin to take on your clinical role 16:13:10
20 of attempting to treat them? 16:13:12
21 A. If a patient wanted to transfer to our office for 16:13:18
22 their care for some reason and we had not heard from 16:13:24
23 a doctor for whatever reason, we would need to know 16:13:30
24 what doctor had been treating them and we would have 16:13:34
25 to have a copy of their pathology report and talk to 16:13:38

1 the referring physician before the patient could be 16:13:42
2 seen in our office. 16:13:44
3 Q. Okay. What is it important for you to know 16:13:52
4 regarding talking to the referring physician about 16:14:02
5 the patient? 16:14:04
6 A. That the patient legitimately has cancer and what 16:14:10
7 they have done in the past for workup and treatment 16:14:14
8 so we are not being redundant. 16:14:18
9 Q. As part of the workup that you do in seeing a 16:14:26
10 patient in your office, do you take a medical 16:14:32

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11 history? 16:14:32

12 A. Yes, as it pertains to their disease. 16:14:38

13 Q. Okay. In taking a history of the patient, is that 16:14:44

14 attained at least in part by the administration of a 16:14:50

15 questionnaire to the patient? 16:14:52

16 A. No. 16:14:54

17 Q. Do you do a personal interview with a patient to 16:15:00

18 collect the information? 16:15:02

19 A. In our office that is the -- that is what we do, the 16:15:06

20 physician does the interview of the patient. 16:15:08

21 Q. Okay. Do you sometimes have nonphysician staff 16:15:14

22 interview patients for the history? 16:15:16

23 A. No, not in our office. 16:15:18

24 Q. Why is it that you're not accepting of a 16:15:24

25 nonphysician staff member of your office to collect 16:15:30

1 information for purpose of the history? 16:15:30

2 A. It's the culture of our office. 16:15:36

3 Q. Okay. Beyond culture, is there a standard of 16:15:44

4 practice for your field of medicine that you have in 16:15:50

5 mind to make you feel more comfortable that a 16:15:54

6 personal interview is called for? 16:15:56

7 A. I don't know that there's necessarily a standard of 16:16:04

8 care. I know other institutions do use 16:16:08

9 questionnaires and format and physician extenders to 16:16:14

10 talk with the patient and get historical data. 16:16:24

11 It's just in our particular office, we've 16:16:26

12 never done that. And it's just our method and mode 16:16:34

13 of practice. 16:16:34

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14 Q. Do you feel that a personal interview to collect 16:16:38
15 information toward a history of the patient is a 16:16:44
16 more reliable method for collecting that information 16:16:48
17 than the administration of a questionnaire? 16:16:50
18 A. Not necessarily. 16:16:52
19 MR. ORENSTEIN: For her treatment purposes 16:16:54
20 are you talking about, in her office? 16:16:56
21 MR. KEMNA: Yes. 16:16:56
22 THE WITNESS: I do not think that it's 16:17:02
23 more reliable or less reliable. It's just the 16:17:06
24 culture of our office. 16:17:06
25 BY MR. KEMNA:

1 Q. Okay. What types of information do you compile in 16:17:16
2 the course of interviewing a patient for history? 16:17:22
3 A. We talk about the history of their disease, what 16:17:28
4 symptoms that they have that brought them to be 16:17:34
5 treated, to be diagnosed. What was their entry 16:17:40
6 point? Why did they seek out physician care that 16:17:46
7 led to the diagnosis of this particular problem? 16:17:52
8 What symptoms had they been having maybe 16:17:56
9 even before it came to the -- to their attention 16:18:02
10 that maybe this was a significant problem? Can they 16:18:06
11 remember back when these symptoms started? 16:18:10
12 What other medical problems have they 16:18:12
13 had? Have they had other surgeries? Have they had 16:18:20
14 any other problems with any other organ systems? 16:18:24
15 Are they allergic to anything? What is their -- 16:18:28

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16 type of jobs do they do? 16:18:32

17 What exposures do they have to medication, 16:18:36

18 drugs, alcohol, tobacco? What is their family 16:18:42

19 history? And, again, are there other things that 16:18:52

20 they, you know, would like to share with us that 16:18:54

21 perhaps we haven't even asked them that are of 16:18:58

22 concern to them? Sometimes those things are 16:19:00

23 financial and other issues that they have. 16:19:06

24 Q. Anything else that you can think of offhand? 16:19:12

25 A. Not anything offhand. 16:19:14

1 Q. Do you have a checklist that you use in interviewing 16:19:20

2 a patient so that you cover all of the standard 16:19:24

3 areas of inquiry? 16:19:24

4 A. A mental checklist. 16:19:28

5 Q. So you don't have a typewritten list or a 16:19:32

6 handwritten list? 16:19:34

7 A. No. 16:19:36

8 Q. You do this all the time, it's sort of second nature 16:19:38

9 to you; is that correct? 16:19:38

10 A. That's correct. 16:19:40

11 Q. You said you ask regarding the occupation of the 16:19:54

12 individual. What relevance does that have to your 16:20:00

13 handling of the patient? 16:20:00

14 A. Obviously, there may be some work exposures that we 16:20:10

15 are interested in. It gives us a basic bit of 16:20:18

16 information as far as, you know, what their 16:20:22

17 knowledge base may be. 16:20:24

18 Are they a health care professional, not a 16:20:28

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19 health care professional? In our treatment of 16:20:30
20 patients with chemotherapy, we frequently give them 16:20:36
21 medications that lower their counts. 16:20:38
22 Do they have a job that would put them at 16:20:42
23 increased risk with respect to infections, for 16:20:46
24 instance? Do they have a job where the fact that we 16:20:54
25 may lower their platelets and they may bleed easier 16:20:58

1 be a significant factor in what we are dealing 16:21:02
2 with? 16:21:02
3 Do they have a job where they cannot maybe 16:21:04
4 get the rest that they would need during a course of 16:21:08
5 a treatment. 16:21:12
6 There are many aspects of a person's work 16:21:14
7 environment that may play a very important role in 16:21:18
8 their ability to tolerate treatment and have that 16:21:24
9 treatment be safe. 16:21:26
10 Q. Does your desire for information regarding 16:21:34
11 occupation provide any assistance toward better 16:21:40
12 refining the exact diagnosis in the patient? 16:21:44
13 MR. ORENSTEIN: Objection; vague and 16:21:54
14 ambiguous. 16:21:54
15 THE WITNESS: I cannot think of a specific 16:22:04
16 instance right now that that information would help 16:22:10
17 in determining the exact diagnosis. 16:22:16
18 If there are instances, somebody would 16:22:20
19 have to give me a specific. But I can't think of 16:22:24
20 any that it's important in making the diagnosis. 16:22:30

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21 BY MR. KEMNA:

22 Q. Does that information regarding occupation 16:22:38

23 contribute to your ability to determine the possible 16:22:50

24 etiology for the patient's condition? 16:22:54

25 MR. ORENSTEIN: Objection. 16:22:58

1 THE WITNESS: The specific etiology of the 16:23:04

2 condition for a medical oncologist is not tantamount 16:23:14

3 in what we need to know to treat the patient. So 16:23:20

4 basically we are looking for information that will 16:23:26

5 help us in making the patient's situation tolerable 16:23:36

6 for them to proceed with their therapy if that's 16:23:44

7 what they choose to do. 16:23:46

8 BY MR. KEMNA:

9 Q. With the information regarding occupation, do you 16:23:54

10 ever attempt to make any determination of the 16:23:58

11 possible etiology for their condition? 16:24:00

12 MR. ORENSTEIN: Objection. 16:24:06

13 THE WITNESS: That would not be something 16:24:14

14 that we would routinely -- I mean, I just -- again, 16:24:22

15 I'm having problems thinking of a case scenario that 16:24:26

16 you might be thinking of, so I can't think of a 16:24:34

17 specific case scenario where that would be a 16:24:36

18 particularly useful bit of information in that 16:24:46

19 situation. 16:24:46

20 BY MR. KEMNA:

21 Q. Does occupation information give you any clue as to 16:24:50

22 potential exposures that the individual may have had 16:24:56

23 to some factor that would possibly be related to 16:25:02

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24 their condition? 16:25:04

25 A. Of historical interest, there may be, but not for a 16:25:12

1 particular patient being necessarily a situation 16:25:20

2 that they would -- that would be useful in us 16:25:22

3 determining what they had, or what the treatment for 16:25:26

4 that disease would be. 16:25:26

5 Q. Okay. And as you've indicated before in your 16:25:42

6 testimony, your objective is perhaps somewhat tied 16:25:58

7 to diagnostic issues regarding lung cancer, but 16:26:04

8 primarily treatment of lung cancer; is that 16:26:08

9 correct?

10 MR. ORENSTEIN: Objection; vague and 16:26:10

11 ambiguous, compound question. 16:26:12

12 BY MR. KEMNA:

13 Q. If you understand the question. 16:26:14

14 A. My role for an oncology patient is to make sure that 16:26:24

15 the staging is complete, that treatment options have 16:26:30

16 been discussed, providing those treatment options 16:26:36

17 include chemotherapy, to make sure that those 16:26:44

18 options are discussed with the patient and 16:26:46

19 administer those drugs, make sure that they have the 16:26:50

20 appropriate referrals to other physicians, such as 16:26:56

21 surgery, radiation, therapy, et cetera, that they 16:27:02

22 need for their treatment to follow them through 16:27:06

23 their treatment and follow them after their 16:27:10

24 treatment is complete for complications of their 16:27:16

25 disease and of the treatment. That's what an 16:27:22

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1 oncologist does. 16:27:24
2 BY MR. KEMNA:
3 Q. In collecting information that relates to history of 16:27:36
4 the patient, you mentioned exposures. Why do you 16:27:42
5 ask about information regarding exposures? 16:27:46
6 A. Again, as part of -- I believe most physicians do 16:27:56
7 that in their history to look at what things 16:28:02
8 patients may have come in contact with. 16:28:08
9 For instance, a breast cancer patient that 16:28:12
10 may have had -- been exposed to x-ray because they 16:28:20
11 had frequent x-rays as a young person for TB, which 16:28:24
12 was -- somebody that had an exposure of radiation 16:28:28
13 for acne and developed a thyroid cancer. Those 16:28:36
14 types of things. 16:28:40
15 Perhaps they haven't developed it, but 16:28:42
16 while we're watching for other issues, we need to 16:28:46
17 know that they've had those exposures and that would 16:28:50
18 be included in our follow-up of them for potential 16:28:56
19 risks for other cancers. 16:29:00
20 The same reason that we ask for family 16:29:02
21 history, to make them aware of other things that 16:29:06
22 they may be at a higher risk for. 16:29:08
23 Q. Okay. So these are other factors that you would 16:29:16
24 describe as risk factors for, for instance, lung 16:29:20
25 cancer; is that accurate? 16:29:22

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1 A. I'm not sure how we made that jump, but for any 16:29:32
2 disease that they may have risk factors for, other 16:29:36
3 disease that, as a physician that will be following 16:29:46
4 this patient, we need to be aware of. 16:29:50
5 Q. I'll hopefully ask a question that's better 16:29:54
6 constructed this time. 16:29:56
7 Your questioning the patient regarding 16:30:04
8 exposures relates to possible risk factors for 16:30:10
9 disease in general. But encompassed within some of 16:30:14
10 the exposures that you may be inquiring about, there 16:30:18
11 may be some relevance in terms of those factors as 16:30:24
12 risks for lung cancer; is that accurate? 16:30:26
13 A. That would be accurate. 16:30:28
14 Q. Do you attempt to identify for your patients, when 16:30:46
15 asking them about exposures, particular types of 16:30:50
16 exposures to draw a yes or no response, or do you 16:30:56
17 seek just volunteer comments about what they may 16:31:00
18 have been exposed to? 16:31:02
19 A. For workplace exposures, I basically ask them what 16:31:12
20 things they -- I ask them about their job situation 16:31:18
21 and if they are aware of any exposures that I should 16:31:26
22 be aware of from their past history, as far as 16:31:34
23 certain specifics, such as drug use, prescription or 16:31:42
24 otherwise, alcohol use, tobacco use. I do ask them 16:31:54
25 specifically about those issues. 16:31:54

1 Q. Do you ever ask them about possible exposure to 16:32:02

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2 asbestos? 16:32:02
3 A. That's part of their -- if they state that they have 16:32:08
4 worked as a plumber or worked in shipyards, 16:32:14
5 whatever, I will ask if they have had any exposure 16:32:20
6 to asbestos. 16:32:20
7 Q. When you ask them about drug use, do you ask about 16:32:32
8 the extent to which they may smoke marijuana? 16:32:36
9 A. I ask them if they use illicit drugs. If they say 16:32:46
10 they do, then I do ask them what type and how often 16:32:50
11 they may use that particular drug or drugs. 16:32:52
12 Q. You would agree, wouldn't you, Doctor, that 16:32:58
13 marijuana has been identified as a risk factor for 16:33:02
14 lung cancer? 16:33:04
15 A. That would have to be in the realm of the 16:33:06
16 epidemiologists. I cannot answer that question. 16:33:12
17 Q. Okay. Do you ask questions about the history of 16:33:36
18 lung diseases that the patient may have had? 16:33:38
19 A. In the review of systems, we ask whether they have 16:33:44
20 had any pulmonary diseases. 16:33:48
21 Q. Okay. What types of pulmonary diseases are of 16:33:54
22 significance to you when collecting this history on 16:34:00
23 a patient? 16:34:04
24 A. Whether they've had problems such as asthma. If so, 16:34:10
25 how long. What have they had for treatment. 16:34:12

1 Whether they've had problems with tuberculosis or 16:34:18
2 any other infection, any chronic problem, chronic 16:34:26
3 bronchitis, emphysema. 16:34:30
4 Basically have they ever seen a doctor for 16:34:32

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5 a problem with their lungs that has been, you know, 16:34:40
6 significant, significant enough for them to 16:34:46
7 remember. 16:34:46
8 Q. Are respiratory infections important in both 16:34:50
9 childhood and adult history? 16:34:54
10 A. Only if they have been, again, significant enough 16:35:00
11 for the patient to remember. 16:35:02
12 Q. For instance, the development of pneumonia in an 16:35:08
13 individual you would consider significant as an 16:35:10
14 aspect of their history; is that correct? 16:35:12
15 A. Again, if it was a significant enough event for them 16:35:18
16 to remember, then it would be significant enough for 16:35:20
17 me to put in the records. 16:35:22
18 Q. Okay. Pneumonia can result in some scarring of the 16:35:28
19 lungs; isn't that correct, Doctor? 16:35:30
20 A. Yes, it can. 16:35:40
21 Q. Is it also true that the condition of tuberculosis 16:35:44
22 can lead to some scarring of the lungs? 16:35:46
23 A. That's correct. 16:35:48
24 Q. Would you agree, Doctor, that a scarring of the 16:35:58
25 lungs has been identified as a factor associated 16:36:08

1 with the later incidence of lung cancer? 16:36:10
2 A. There's something called -- that used to be called 16:36:14
3 scar carcinoma. I have not seen that terminology in 16:36:20
4 recent path reports, but in the area where someone 16:36:24
5 has a scar, they pathologically develop a cancer 16:36:30
6 within that scar tissue. 16:36:32

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7 Q. So it is true, isn't it, Doctor, that a history of 16:36:48
8 tuberculosis can have some significance toward the 16:36:52
9 question of whether a patient is at an increased 16:36:56
10 risk for the development of lung cancer? 16:36:58
11 MR. ORENSTEIN: Objection. 16:36:58
12 THE WITNESS: That could be a risk 16:37:06
13 factor. The, again, significance of that 16:37:14
14 percentage-wise would have to be addressed by an 16:37:20
15 epidemiologist. 16:37:22
16 BY MR. KEMNA:
17 Q. Doctor, you'd agree that traumatic injuries to the 16:37:42
18 thoracic region in an individual can result in 16:37:48
19 damage to the lungs that could result in a scar? 16:37:56
20 A. That's true. 16:37:58
21 Q. Do you sometimes see evidence of scarring in the 16:38:08
22 lungs that has resulted in -- I'm sorry, let me 16:38:14
23 rephrase the question. 16:38:16
24 Do you sometimes observe evidence of 16:38:22
25 traumatic injury to the lungs that has resulted in 16:38:26

1 scarring within the lung tissue? 16:38:28
2 A. Occasionally. 16:38:30
3 Q. And in the same respect that scarring of the lungs 16:38:36
4 that has been associated with tuberculosis can 16:38:42
5 result in increased risk for lung cancer, is it fair 16:38:46
6 to say that traumatic injury to the lung that 16:38:48
7 results in scarring is also a risk factor for the 16:38:56
8 development of lung cancer? 16:38:56
9 MR. ORENSTEIN: Objection; lack of 16:38:58

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10 foundation. 16:39:00

11 THE WITNESS: I do not -- yes, I cannot 16:39:02

12 say that. I do not know the data on that or whether 16:39:06

13 that -- what the numbers are for something like 16:39:10

14 that. 16:39:10

15 I've certainly never seen that scenario. 16:39:14

16 But that you would have to ask an epidemiologist, 16:39:20

17 such as Dr. Samet, whether that is a factor. 16:39:26

18 BY MR. KEMNA:

19 Q. Doctor, do you know whether a poor nutritional 16:39:50

20 status has been associated with the incidence of 16:39:54

21 lung cancer? 16:39:56

22 A. No, I do not. 16:39:56

23 Q. Do you know whether a high-fat diet has been 16:40:06

24 associated with an increased incidence of cancer, 16:40:10

25 lung cancer? 16:40:10

1 A. I have not seen any data on that. 16:40:14

2 Q. Do you know whether a diet insufficient in 16:40:44

3 antioxidants is associated with the increased 16:40:50

4 incidence of lung cancer? 16:40:52

5 A. I've not seen any data on that. 16:40:54

6 Q. Have you seen any data relating low levels of 16:41:02

7 vitamin consumption in the diet being associated 16:41:06

8 with increased incidence of lung cancer? 16:41:08

9 A. I have not seen any data on that. 16:41:12

10 Q. Have you seen data on exposure to radon in the home 16:41:40

11 being associated with an increased incidence of lung 16:41:44

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12 cancer? 16:41:44

13 A. I've not seen specific numbers on that and that 16:41:50

14 would be an area that the epidemiologist may indeed 16:41:54

15 have numbers on. 16:41:56

16 Q. You are not comfortable with offering an opinion, 16:42:00

17 then, on any relationship between radon and lung 16:42:02

18 cancer; is that correct? 16:42:02

19 A. That's correct. 16:42:02

20 Q. Doctor, in taking histories on your patients -- 16:42:42

21 well, let's back away from that for the moment. 16:42:48

22 Within the population of patients that you 16:42:52

23 treat, there are those that have their medical 16:43:00

24 expenses reimbursed through the State of Minnesota's 16:43:04

25 Medicaid program; is that correct? 16:43:06

1 A. That is correct. 16:43:08

2 Q. In taking histories of patients, do you note any 16:43:22

3 difference in factors that relate to disease between 16:43:28

4 those that are within the population of Medicaid 16:43:32

5 patients versus those that would be considered 16:43:34

6 within the general third-party payment population or 16:43:42

7 private-payer population, other than Medicaid 16:43:44

8 patients? 16:43:46

9 MR. ORENSTEIN: Objection; overbroad, 16:43:48

10 vague. 16:43:48

11 THE WITNESS: I do not notice any 16:43:52

12 difference. But I also do not specifically look at 16:43:56

13 a person's insurance when treating them. But I see 16:44:10

14 no difference in the broad population of patients 16:44:12

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15 depending on their insurance. 16:44:12

16 BY MR. KEMNA:

17 Q. When you see a patient in your practice, do you make 16:44:18

18 it a point to recognize whether they are a Medicaid 16:44:22

19 patient or an otherwise private-paying patient? 16:44:26

20 MR. ORENSTEIN: Objection; asked and 16:44:28

21 answered. 16:44:28

22 BY MR. KEMNA:

23 Q. You can go ahead and answer. 16:44:34

24 THE WITNESS: I'm sorry, I did not hear 16:44:36

25 your objection. 16:44:36

1 MR. ORENSTEIN: Oh, I said objection; 16:44:38

2 asked and answered. 16:44:40

3 THE WITNESS: Okay. Yes, I do not look at 16:44:42

4 the type of insurance my patients have. 16:44:46

5 BY MR. KEMNA:

6 Q. Okay. So you would, I take it, feel unprepared at 16:44:54

7 this point to say that you can note any difference 16:44:58

8 in factors that may relate to disease between your 16:45:06

9 Medicaid patients versus your private-paying 16:45:08

10 patients; is that correct? 16:45:10

11 MR. ORENSTEIN: Objection; vague and 16:45:12

12 ambiguous, asked and answered. 16:45:14

13 THE WITNESS: I see no difference because 16:45:20

14 I do not pay attention to the type of insurance that 16:45:26

15 patients have and do not have any obvious difference 16:45:30

16 in populations that would make me want to ask that 16:45:36

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17 question of them. 16:45:38

18 BY MR. KEMNA:

19 Q. Okay. Doctor, you've indicated that collecting this 16:46:00

20 information in the history has importance toward 16:46:04

21 maybe additional clues on diagnosis but staging and 16:46:08

22 treatment of disease. 16:46:14

23 Do you ever take it upon yourself to use 16:46:16

24 the information collected in taking the history on a 16:46:22

25 patient to attempt to determine the cause of the 16:46:28

1 patient's current condition for which they're being 16:46:34

2 treated? 16:46:34

3 MR. ORENSTEIN: Objection; 16:46:36

4 mischaracterizes the testimony. 16:46:38

5 THE WITNESS: I would have trouble 16:46:44

6 answering that because I do not fully understand the 16:46:48

7 question. 16:46:48

8 BY MR. KEMNA:

9 Q. Okay. I'll trim off the preamble and get to the 16:46:58

10 question. 16:47:00

11 Do you use the information that you 16:47:04

12 collect on the patient through the process of taking 16:47:10

13 a history of the patient to determine the cause of 16:47:18

14 the patient's condition? 16:47:20

15 MR. ORENSTEIN: Objection. 16:47:24

16 THE WITNESS: As far as the treatment of 16:47:30

17 the patient and the workup and staging, I do not 16:47:38

18 need to try to determine the cause for that specific 16:47:44

19 patient to care for them, and so I do not 16:47:50

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20 specifically go through any special procedure to 16:47:58
21 look at cause in it for an individual, no. 16:48:08
22 BY MR. KEMNA:
23 Q. For example, Doctor, in taking the history on a 16:48:34
24 patient, if you note that they are a cigarette 16:48:38
25 smoker and they have a diagnosis of lung cancer, you 16:48:44

1 do not draw a conclusion regarding whether the 16:48:48
2 cigarette smoking caused the lung cancer; is that 16:48:54
3 accurate? 16:48:54
4 MR. ORENSTEIN: For that patient, is that 16:48:58
5 what you're asking? 16:48:58
6 MR. KEMNA: Yes. 16:48:58
7 THE WITNESS: For that patient, it is not 16:49:02
8 an important -- at that phase in the patient's 16:49:08
9 disease, the important factors are what they have, 16:49:14
10 what stage it is, what can we do about it, and what 16:49:18
11 do we expect for that patient in the future. 16:49:22
12 So I do not use that information as far as 16:49:30
13 having to report out what the cause is. I will 16:49:34
14 document that the patient is a smoker on the 16:49:38
15 record. And I will talk with the patient about the 16:49:44
16 fact that the -- that I would recommend that they 16:49:50
17 stop smoking at this juncture. 16:49:54
18 But I do not use that information for any 16:50:00
19 treatment purposes or causation purposes for that 16:50:08
20 patient. It is not significant in an individual 16:50:10
21 patient. 16:50:12

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22 BY MR. KEMNA:

23 Q. Have you ever told a patient that their lung cancer 16:50:16

24 was caused by cigarette smoking? 16:50:18

25 A. Is there a reason to specifically tell a person 16:50:26

1 that? 16:50:28

2 Q. Well, that's really not the question. The question 16:50:34

3 is whether you've done it. The rationale we can get 16:50:42

4 into after that, if you like. 16:50:44

5 A. I do not feel that it adds to a patient's treatment 16:50:52

6 or their quality of life by telling them that their 16:51:00

7 cancer is caused by their cigarette smoking or that 16:51:04

8 there's a significant association. If a cancer 16:51:12

9 patient asks me, I will answer their question. 16:51:14

10 Q. If a patient asks you, have you given the response 16:51:42

11 that for that patient their cancer was caused by 16:51:48

12 cigarette smoking? 16:51:48

13 MR. ORENSTEIN: Objection; assumes facts 16:51:50

14 not in evidence, calls for speculation, lack of 16:51:54

15 foundation. 16:51:56

16 THE WITNESS: You would have to give me 16:52:00

17 the specific patient that you were talking about and 16:52:02

18 I could answer that. 16:52:04

19 BY MR. KEMNA:

20 Q. Have you ever told a patient that their cancer is 16:52:10

21 caused by cigarette smoking, whether it is 16:52:14

22 volunteered by you or the inquiry is made of you by 16:52:18

23 the patient? 16:52:18

24 A. I would have to look at the specific patient as to 16:52:24

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25 what I told them specifically. 16:52:28

1 Q. You don't have any present recollection of whether 16:52:30
2 you've ever done that with any patient in your 16:52:34
3 practice; is that correct? 16:52:34
4 A. I could not tell you -- I could not give you a 16:52:42
5 specific patient that I've done that to, no. 16:52:44
6 MR. KEMNA: Let's take a break. 16:52:56
7 THE VIDEOGRAPHER: We're off the video 16:52:58
8 record. The time is 4:53 p.m. 16:53:02
9 (Off the record.) 16:53:02
10 THE VIDEOGRAPHER: We're back on the video 17:03:54
11 record. The time is 5:04 p.m. 17:03:58
12 BY MR. KEMNA:
13 Q. Doctor, another item among information you collect 17:04:12
14 in taking the history on a patient is family 17:04:20
15 history; is that correct? 17:04:20
16 A. That's correct. 17:04:22
17 Q. What is within the category of family history 17:04:30
18 information? 17:04:30
19 A. Age of parents or age of parents at death; numbers 17:04:46
20 of brothers and sisters, whether they are alive or 17:04:48
21 dead; anyone that's died, what they died of; what 17:04:56
22 diseases the living members of the family may have. 17:04:58
23 And then if there are any diseases that 17:05:04
24 run in their grandparents, aunts and uncles that 17:05:12
25 stand out for the patients. 17:05:14

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1 Q. Is a history of lung cancer within the family of a 17:05:28
2 patient significant toward the question of whether 17:05:32
3 that patient is at increased risk for developing 17:05:36
4 lung cancer? 17:05:36
5 MR. ORENSTEIN: Objection; lack of 17:05:38
6 foundation. 17:05:38
7 THE WITNESS: I think you'd have to look 17:05:42
8 at studies trying to look at familial diseases, 17:05:50
9 perhaps through a geneticist to answer that 17:05:54
10 question. 17:05:54
11 BY MR. KEMNA:
12 Q. Would you agree, Doctor, that it's been reported in 17:05:58
13 the literature that a family history of lung cancer 17:06:02
14 is a risk factor for the incidence of lung cancer? 17:06:08
15 MR. ORENSTEIN: Objection; lack of 17:06:10
16 foundation. 17:06:10
17 THE WITNESS: I would have to look at the 17:06:14
18 context in which that statement was made. 17:06:16
19 BY MR. KEMNA:
20 Q. Is family history a risk factor for the incidence of 17:06:26
21 lung cancer? 17:06:26
22 MR. ORENSTEIN: Objection; lack of 17:06:28
23 foundation. 17:06:28
24 THE WITNESS: I would have to review data 17:06:32
25 before I could answer that question. 17:06:34

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1 BY MR. KEMNA:
2 Q. Okay. So at this point, you're not in a position to 17:06:40
3 express an opinion on whether family history is a 17:06:44
4 risk factor for lung cancer; is that accurate? 17:06:46
5 A. That is correct. 17:06:48
6 Q. You mentioned that in working up a patient you want 17:07:22
7 to have information regarding the pathology 17:07:26
8 diagnosis when you're dealing with a patient 17:07:34
9 purportedly with lung cancer; is that correct? 17:07:38
10 A. That's correct. 17:07:38
11 Q. What type of procedures are conducted to collect 17:07:46
12 pathology specimens for evaluation by microscopy? 17:08:02
13 MR. ORENSTEIN: Objection; lack of 17:08:06
14 foundation. 17:08:06
15 THE WITNESS: I'm not exactly sure what 17:08:08
16 you're even asking. 17:08:08
17 BY MR. KEMNA:
18 Q. Let me try it again. What kind of procedures are 17:08:16
19 used by medical practitioners to collect specimens 17:08:20
20 for pathology assessment? 17:08:26
21 MR. ORENSTEIN: Objection; lack of 17:08:30
22 foundation. 17:08:30
23 THE WITNESS: Again, that question is 17:08:42
24 quite broad and I'm not sure what you are referring 17:08:46
25 to. 17:08:46

1 BY MR. KEMNA:
2 Q. Okay. Before you see your patients, are they often 17:08:54

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3 seen by a pulmonologist? 17:08:56

4 A. They may have been seen by a pulmonologist, yes. 17:09:04

5 Q. Okay. Do you know of procedures that are used by 17:09:10

6 pulmonologists to collect pathology specimens? 17:09:12

7 A. Bronchoscopy would be a method. 17:09:18

8 Q. Do you know of the different methods used to obtain 17:09:24

9 specimens for pathology by bronchoscopy? 17:09:34

10 A. You'd have to ask the pulmonologists what methods 17:09:36

11 they use. 17:09:36

12 Q. Are you familiar with the difference between biopsy 17:09:44

13 specimens versus cytology specimens? 17:09:50

14 A. Am I aware of the differences between the two? 17:09:56

15 Q. Yes. 17:09:56

16 A. Is that the question? 17:09:58

17 Q. Yes. 17:09:58

18 A. Yes. 17:09:58

19 Q. Okay. What are the differences? 17:10:02

20 A. Biopsy has -- well, cytology is where you have cells 17:10:10

21 that you smear across a slide, fix that slide, and 17:10:16

22 evaluate that tissue, or take a specimen where the 17:10:28

23 cells are collected and you try to spin them down to 17:10:34

24 form enough of a block to look at as a lump of 17:10:40

25 tissue. 17:10:40

1 A biopsy is where you actually collect 17:10:44

2 tissue that is -- has too many cell layers to smear 17:10:50

3 on a slide and look at it that way. So you need to 17:10:54

4 fix it and cut it to put it on a slide and stain 17:11:00

5 it. 17:11:00

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6 Q. Okay. Among the methods used to collect cytology 17:11:08
7 specimens, would you include the collection of 17:11:14
8 sputum? 17:11:16
9 A. That can be used, yes. 17:11:20
10 Q. Among methods to collect cytology specimens, would 17:11:30
11 you include bronchial washings? 17:11:32
12 A. Those are used. 17:11:34
13 Q. Okay. Do you know how pulmonologists collect 17:11:42
14 bronchial washings during a bronchoscopy procedure? 17:11:46
15 A. No, I do not. 17:11:48
16 Q. Do you know if the specimen collected in a bronchial 17:11:52
17 washing is specific to the area of the tumor? 17:11:54
18 A. No, I do not. 17:11:56
19 Q. Among the procedures used to collect cytology 17:12:20
20 specimens, would you include bronchial brushings? 17:12:22
21 A. Yes, those are done. 17:12:26
22 Q. Okay. Do you know how the pulmonologist goes about 17:12:30
23 collecting bronchial brushing specimens? 17:12:34
24 A. No, I do not. 17:12:36
25 Q. Do you know whether those brushing specimens are 17:12:38

1 specific to the region of the presentation of the 17:12:40
2 tumor? 17:12:40
3 A. No, I do not. 17:12:42
4 Q. Would you agree, Doctor, that obtaining a biopsy 17:12:52
5 specimen that includes a cross-section of tissue 17:13:04
6 would be a more reliable basis to form a pathology 17:13:10
7 diagnosis than a cytology specimen? 17:13:14

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8 A. You'd have -- 17:13:16

9 MR. ORENSTEIN: Objection; lack of 17:13:16

10 foundation. 17:13:18

11 THE WITNESS: You'd have to ask a 17:13:20

12 pathologist because they're the ones that need to 17:13:22

13 make that distinction. I would not have any way of 17:13:26

14 knowing. 17:13:26

15 BY MR. KEMNA:

16 Q. If you only have cytology reports regarding, say, 17:13:44

17 sputum cytology, are you comfortable with accepting 17:13:50

18 a diagnosis of lung cancer from the patient? 17:13:52

19 A. I would have to have more information on that 17:14:02

20 patient. 17:14:02

21 Q. If that patient otherwise presented with a shadow in 17:14:14

22 their lung by x-ray and showed positive findings on 17:14:28

23 a cytology specimen, would you feel comfortable that 17:14:32

24 that's a sufficient basis for diagnosing lung 17:14:36

25 cancer? 17:14:36

1 A. I'd have to evaluate the patient more thoroughly 17:14:42

2 than that before making -- coming to such a 17:14:46

3 conclusion. 17:14:46

4 Q. To the best of your ability, would you tell me what 17:14:50

5 other information you would need in order to make 17:14:52

6 the diagnosis of lung cancer in such a patient? 17:14:56

7 MR. ORENSTEIN: Objection; lack of 17:14:58

8 foundation. 17:14:58

9 THE WITNESS: Again, it would -- I would 17:15:04

10 need more information on the patient's workup and 17:15:08

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11 other supporting information. 17:15:10

12 BY MR. KEMNA:

13 Q. Can you make a diagnosis of lung cancer in a patient 17:15:18

14 without a pathologist's diagnosis of the tissue? 17:15:22

15 MR. ORENSTEIN: Objection; lack of 17:15:24

16 foundation. 17:15:24

17 THE WITNESS: Again, that's dealing with a 17:15:28

18 solitary patient and I can't make any comment on the 17:15:32

19 treatment or diagnosis of an individual patient 17:15:36

20 without reviewing their records and seeing the 17:15:42

21 patient and seeing what has been done. That is just 17:15:48

22 speculation. 17:15:48

23 BY MR. KEMNA:

24 Q. Well, let's talk about what is feasible based upon 17:15:54

25 information available to you. If you have the other 17:16:16

1 information that you might deem adequate to make an 17:16:20

2 assessment of a patient for treatment purposes, but 17:16:22

3 you have no pathology diagnosis that says "we have 17:16:28

4 collected this tissue specimen and it is reflective 17:16:32

5 of malignancy," can you make a diagnosis of lung 17:16:36

6 cancer in such a patient? 17:16:38

7 MR. ORENSTEIN: Objection; lack of 17:16:40

8 foundation. 17:16:40

9 THE WITNESS: Again, I would have to see 17:16:44

10 the patient and see the records before making that 17:16:48

11 -- answering that yes or no. 17:16:52

12 BY MR. KEMNA:

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13 Q. Okay. Doctor, have you reviewed any data that 17:17:14
14 studies the level of agreement between what a 17:17:24
15 patient's view of their disease process is compared 17:17:26
16 against their treating physician's view of what 17:17:30
17 their disease process is? 17:17:32
18 A. No, I have not. 17:17:34
19 Q. Okay. Would you be surprised to find out that there 17:17:38
20 is a great degree of disagreement between what a 17:17:42
21 patient might regard as their disease condition and 17:17:44
22 what the physician provider would think -- 17:17:48
23 MR. ORENSTEIN: Objection.
24 BY MR. KEMNA:
25 Q. -- or have made a diagnosis of their disease 17:17:50

1 condition? 17:17:50
2 MR. ORENSTEIN: Objection; assumes facts 17:17:54
3 not in evidence, calls for speculation. 17:17:56
4 THE WITNESS: That would be very 17:17:58
5 speculative. I would definitely have to look at 17:18:00
6 those studies. 17:18:02
7 BY MR. KEMNA:
8 Q. When you're doing the initial workup on a patient, 17:19:08
9 one of the areas that you're concerned with is the 17:19:16
10 patient's report of symptoms associated with the 17:19:20
11 condition; is that correct? 17:19:22
12 A. That's correct. 17:19:22
13 Q. Is it common for you to see patients in your office 17:19:38
14 that report persistent coughing? 17:19:44
15 A. It's not uncommon. 17:19:48

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16 Q. When you see a patient who has had symptoms of 17:19:56
17 coughing for an extended period of time, do you 17:19:58
18 formulate a diagnosis as to what their condition 17:20:02
19 is? 17:20:02
20 MR. ORENSTEIN: Objection; lack of 17:20:04
21 foundation. 17:20:04
22 THE WITNESS: Again, you'd have to look at 17:20:12
23 the patient's specific case. But any patient that 17:20:20
24 complains of any problem, you do try to evaluate 17:20:24
25 that problem, if that's what you're asking. 17:20:26

1 BY MR. KEMNA:
2 Q. Do you ever make diagnoses of bronchitis? 17:20:32
3 A. On occasion. 17:20:36
4 Q. What information is necessary in order for you to 17:20:42
5 make a diagnosis of bronchitis? 17:20:44
6 A. Again, depending upon the patient, their disease 17:20:58
7 entity, their x-rays, their symptoms, fever, sputum 17:21:04
8 production. There's many factors that go into that 17:21:08
9 diagnoses. 17:21:10
10 Q. Is it necessary for the patient to have any 17:21:16
11 particular presentation by x-ray in order to make a 17:21:18
12 diagnosis of bronchitis? 17:21:20
13 A. Basically if this is purely a presentation of 17:21:32
14 bronchitis, you would be more likely to see a normal 17:21:40
15 chest x-ray than a chest x-ray with an abnormality. 17:21:46
16 But since symptoms with bronchitis tend to 17:21:48
17 be persistent coughing, perhaps some productivity, 17:21:52

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18 you need to evaluate whether they are having a drug 17:21:56
19 effect, if they have a pneumonia, if they have other 17:21:58
20 pulmonary processes going. 17:22:02
21 So it's a very complicated thing in our 17:22:04
22 patients. We have many potential reasons for a 17:22:10
23 persistent cough. 17:22:12
24 Q. Now, we've been referring to the term of 17:22:18
25 "bronchitis." Do you need to see any particular 17:22:22

1 additional information in order to categorize the 17:22:26
2 patient as having chronic bronchitis? 17:22:28
3 A. You'd have to ask a pulmonologist how they define 17:22:34
4 that. I do not make a diagnosis as to whether 17:22:38
5 somebody has chronic bronchitis or not. Their 17:22:42
6 pulmonary doctor would make that diagnoses. 17:22:46
7 Q. Have you ever seen diagnoses of bronchitis in a 17:23:16
8 patient that you believe does not present to you 17:23:18
9 with the symptoms and underlying foundation for 17:23:24
10 making the diagnosis of bronchitis? 17:23:26
11 A. I don't remember any specific cases, no. 17:23:36
12 Q. What kind of factors are associated with the onset 17:24:08
13 of bronchitis? 17:24:08
14 MR. ORENSTEIN: Objection; lack of 17:24:14
15 foundation. 17:24:14
16 THE WITNESS: I would definitely have you 17:24:16
17 ask that of a pulmonologist. 17:24:18
18 BY MR. KEMNA:
19 Q. You have no opinion regarding what factors may be 17:24:24
20 associated with the incidence of bronchitis? 17:24:34

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21 A. I do not treat people specifically for that 17:24:34
22 disease. If I feel somebody has a chronic pulmonary 17:24:36
23 disease that is not directly associated with what 17:24:38
24 I'm doing or the treatment of their cancer, I refer 17:24:40
25 them back either to their internist or to a 17:24:44

1 pulmonologist to assess the etiology of their 17:24:48
2 symptoms. 17:24:48
3 Q. Doctor, are you a smoker? 17:25:10
4 A. No. 17:25:12
5 Q. Have you ever smoked? 17:25:12
6 A. Never smoked cigarettes. 17:25:14
7 Q. Ever smoke cigars? 17:25:20
8 A. I've had two puffs of a cigar when I was a freshman 17:25:26
9 in college for somebody's baby. That's the sum 17:25:32
10 total of my smoking history. 17:25:34
11 Q. Ordinarily, I wouldn't ask that question, but it 17:25:36
12 seems to be a trend these days. 17:25:38
13 A. I know. It is. But that was enough for me. 17:25:44
14 Q. Doctor, are you familiar with Devita's text 17:26:04
15 entitled, "Cancer Principles And Practice Of 17:26:08
16 Oncology"? 17:26:08
17 A. Yes. 17:26:10
18 Q. Would you consider that one of the most prominent 17:26:14
19 texts in your field of practice? 17:26:16
20 A. It's a very well thought of text, yes. 17:26:20
21 Q. Okay. Would you consider that text to be 17:26:22
22 authoritative in the field of oncology? 17:26:26

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23 MR. ORENSTEIN: Objection; overbroad. 17:26:28

24 THE WITNESS: You'll have to define the 17:26:30

25 term "authoritative." 17:26:32

1 BY MR. KEMNA:

2 Q. Is Devita's text one that you readily refer to in 17:26:38

3 your practice for some guidance on aspects of the 17:26:42

4 clinical practice of oncology? 17:26:44

5 A. I may refer to Devita two to four times a year, but 17:26:52

6 not readily. 17:26:56

7 Q. Would you consider the information provided in 17:26:58

8 Devita's text to be accurate and reliable as an 17:27:12

9 information source for the practice of the field of 17:27:14

10 oncology? 17:27:14

11 MR. ORENSTEIN: Objection; overbroad. 17:27:16

12 THE WITNESS: It would definitely depend 17:27:18

13 on what aspect you were talking about. 17:27:20

14 BY MR. KEMNA:

15 Q. You've got a copy of Devita's text in your office, I 17:27:26

16 take it? 17:27:26

17 A. Absolutely. 17:27:28

18 Q. Do you have any pulmonary pathology texts in your 17:27:36

19 office? 17:27:36

20 A. We may. I do not have a catalog of all the texts 17:27:48

21 that we have in our office. 17:27:50

22 Q. Are you familiar with Dail & Hammar's text on 17:27:58

23 "Pulmonary Pathology"? 17:28:02

24 A. No. 17:28:02

25 Q. Are you familiar with Thurlbeck & Churg's text on 17:28:08

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1 "Pathology of the Lung"? 17:28:10
2 A. No. 17:28:10
3 Q. Are you familiar with a text called "Comprehensive 17:28:20
4 Textbook of Thoracic Oncology"? 17:28:22
5 A. I have seen that textbook, but I am not familiar 17:28:26
6 with it. 17:28:26
7 Q. Do you think you have a copy of it in your office? 17:28:32
8 A. There are 14 doctors in our subgroup. We could have 17:28:40
9 anything in our office. 17:28:42
10 Q. What medical journals do you review on a regular 17:28:50
11 basis? 17:28:52
12 A. I get the "Journal of Clinical Oncology" on a 17:28:54
13 regular basis. We get the "Journal of Clinical 17:29:04
14 Trials," and "Oncologic News." There are many 17:29:16
15 journals that come even without us ordering them. 17:29:22
16 And basically I look through the index for 17:29:28
17 articles that are relevant to what I do and look at 17:29:30
18 those articles, but not necessarily reviewing the 17:29:34
19 journal on any regular basis. 17:29:36
20 Q. You mentioned that you've referred to Devita's text 17:29:48
21 in the course of your practice. Are there any other 17:29:50
22 texts that come to mind that you refer to? 17:29:54
23 A. There are some specific texts on certain disease 17:30:12
24 entities, like diseases of -- certain diseases of 17:30:20
25 the breast and such, but not any text that I rely 17:30:24

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on. 17:30:26
Specifically most of us rely on journal 17:30:28
articles that tend to be more up-to-date in the 17:30:34
treatment of our patients. Most textbooks, as far 17:30:38
as treatment, have been in the process of being 17:30:44
published for some time. 17:30:46
So we're much more likely to rely on 17:30:48
journal articles that fit the needs of our patients 17:30:52
at the present time than on textbooks. 17:30:54
Q. Have you ever made any speeches or public 17:31:24
presentations that relate to the general subject 17:31:30
area of smoking and health? 17:31:32
A. No. 17:31:34
Q. Do you belong to any organizations that have as at 17:31:40
least one of their objectives discouraging cigarette 17:31:44
smoking? 17:31:44
MR. ORENSTEIN: Objection; lack of 17:31:48
foundation. 17:31:48
THE WITNESS: I would have to investigate 17:31:54
that. 17:31:54
BY MR. KEMNA:
Q. Okay. Do you have any affiliation or otherwise 17:32:06
involvement with the American Cancer Society? 17:32:10
A. Yes. 17:32:14
Q. Okay. In what role are you involved with the 17:32:18

American Cancer Society? 17:32:20

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2 A. I deal with them -- intermittently I will answer 17:32:28
3 their phone banks for patient call-ins. I will 17:32:36
4 volunteer for some of their meetings where they need 17:32:42
5 a physician to answer patient questions. 17:32:50
6 I do some -- just various things like that 17:32:56
7 where they need a physician to answer a patient's 17:32:58
8 questions, basically. 17:33:00
9 Q. Okay. Are you involved with the American Lung 17:33:12
10 Association?
11 A. No. 17:33:14
12 Q. Are you involved with the American Thoracic 17:33:20
13 Society?
14 A. No. 17:33:20
15 Q. Have you ever been involved with or affiliated with 17:33:34
16 Stop Teenage Addiction to Smoking? 17:33:38
17 A. No. 17:33:40
18 Q. I meant to ask this a little bit earlier, but does 17:33:50
19 anybody in your family smoke? 17:33:50
20 MR. ORENSTEIN: Objection; overbroad. 17:34:00
21 THE WITNESS: Does anybody in my family 17:34:00
22 smoke? How far back? 17:34:02
23 BY MR. KEMNA:
24 Q. Immediate family. 17:34:04
25 A. My children and my husband and my parents do not 17:34:04

1 smoke. 17:34:04
2 Q. If someone were to visit your home, would they be 17:34:10
3 permitted to smoke in your home? 17:34:12

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A. No, they would not. 17:34:14

MR. KEMNA: Why don't we stop there. 17:34:24

THE VIDEOGRAPHER: This is the end of tape 17:34:26

2 of Dr. Barbara Bowers' deposition. The time is 17:34:30

5:34 p.m. 17:34:34

(Off the record.) 17:34:34

STATE OF MINNESOTA)

) ss.

COUNTY OF HENNEPIN)

Be it known that the foregoing proceedings were

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taken by Jennifer S. Sati, RPR, CRR on the 23rd day of July, 1997, at Minneapolis, Minnesota;

That I was then and there a Notary Public in and for the County of Hennepin, State of Minnesota, and that by virtue thereof, I was duly authorized to administer an oath;

That the Proceedings were recorded in stenotype by myself and transcribed into writing by computer-aided transcription, and that the transcript is a true record of the testimony given to the best of my ability;

Dated and signed this 8th day of August, 1997.

_____
Jennifer S. Sati, RPR, CRR
Court Reporter

ERRATA SHEET

RE: Minnesota Tobacco Litigation
Barbara J. Bowers, M.D., Volume I

I, BARBARA J. BOWERS, M.D., do hereby certify that I have read the foregoing transcript of the proceedings taken on July 23, 1997, and believe the same to be true and correct, except as follows:

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19 _____ _____
Date Notary

20

21 _____ _____
Date Signature of Witness

22

PLEASE RETURN TO: Jennifer S. Sati, RPR, CRR
23 Ray J. Lerschen & Associates
620 Plymouth Building
24 12 South Sixth Street
Minneapolis, Minnesota 55402-1519

25

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